

No Time to Waste

PROGRAMS TO REDUCE TEEN PREGNANCY AMONG MIDDLE SCHOOL-AGED YOUTH

By Jennifer Manlove, Ph.D Kerry Franzetta Krystal McKinney Angela Romano Papillo, M.A. Elizabeth Terry-Humen, M.P.P.

February 2004





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Acknowledgements

No Time to Waste is part of the National Campaign to Prevent Teen Pregnancy's Putting What Works to Work (PWWTW) project, an effort to publish and disseminate the latest research on teen pregnancy in straightforward, easy-to-understand language and provide clear implications for policy, programs, and parents. PWWTW is funded by the Centers for Disease Control and Prevention (CDC) and is supported by grant number U88/Ccu322139-01. Materials developed as part of this project are solely the responsibility of the authors and do not necessarily represent the official views of CDC. The National Campaign wishes to thank the CDC for their support of this portion of the National Campaign's research program.

The National Campaign also gratefully acknowledges its many funders. Special thanks go to the David and Lucile Packard Foundation, the Robert Wood Johnson Foundation, the Roger and Vicki Sant Fund of the Community Foundation for the National Capital Region, the William and Flora Hewlett Foundation, and the John D. and Catherine T. MacArthur Foundation for generously supporting the full range of Campaign activities.

The National Campaign and the authors of this report thank the members of the PWWTW Scientific Advisory Committee for their helpful comments on early drafts of this document. Without question, their careful review and advice has made this a much more useful document.

Child Trends would like to thank Kristin Moore, who provided edits and comments on the documents, and Erum Ikramullah and Chelsea Richmond for their careful edits to various versions of the report.

Last, but certainly not least, the National Campaign wishes to express deep appreciation to Child Trends, our colleague organization and partner in this project, and, in particular, the authors of this report. Child Trends continues to provide high-quality research of children's issues. *No Time to Waste* is simply the latest example of this leadership.

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ISBN: 1-58671-051-6

Suggested citation: Manlove, J, Franzetta, K, McKinney, K, Romano-Papillo, A, & Terry-Humen, E.(2004). *No time to waste: Programs to reduce teen pregnancy among middle school-aged youth.* Washington, DC: National Campaign to Prevent Teen Pregnancy.

Design: amp&rsand graphic design, inc. Washington, DC + Boulder, CO www.ampersand-design.com

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Note to Reader

Those in states and communities working directly with young people are often the first to note that there are many wonderful community-level and school-based programs that appear to reduce teen pregnancy. Over the past several years, a growing body of scientific evidence has been developed supporting this belief. In recent years, much more has been learned about the relative effectiveness of teen pregnancy prevention programs. Indeed, careful research has shown that a wide range of programs — from sex and HIV education to programs that encourage young people to participate in community service — can be effective in delaying the onset of sex, increasing the use of contraception, and decreasing teen pregnancy.

This is a heartening development given that, until quite recently, little was known about what programs might be most efficacious in preventing teen pregnancy. This growing pool of "effective" programs is particularly good news for communities searching for programmatic answers to still-high rates of teen pregnancy. While many communities have already been putting this knowledge to work on the front lines, others continue to look for guidance about what programs to put in place.

No Time to Waste provides detailed descriptions of those programs for middle school-aged youth

that have been shown through careful research to have a positive impact on adolescent sexual behavior. In addition to providing results from program evaluations, No Time to Waste contains practical information on the costs and availability of program curriculum and lengthy descriptions of what is covered in each curriculum. No Time to Waste joins the expanding base of program evaluation literature from which communities can draw in making their decisions about what programs they might consider using. (Those interested in learning more about effective teen pregnancy prevention programs are encouraged to visit the National Campaign's website — www.teenpregnancy.org to review the findings contained in the publications, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy; A Good Time: After-School Programs to Reduce Teen Pregnancy; and for other relevant materials. We also encourage readers to visit the Child Trends website — www.childtrends. org — to review their helpful charts on "what works" in adolescent reproductive health.)

As important and helpful as these findings are, it is also very important to put this report in context. When assessing the effectiveness of programs, readers are encouraged to keep in mind the following:

These findings *only* reflect those programs that have been evaluated. Only a handful of programs to reduce teen pregnancy among middle school-aged youth have been evaluated at all and, of those, fewer still have been studied using rigorous research designs. Consequently, we know less than we would like to about the efficacy of programs in preventing teen pregnancy. It may very well be that there are any number of creative programs that are effective in helping young adolescents avoid risky sexual behavior that simply have not been evaluated at all.

What do you mean by effective? What makes a program "effective" or "successful?" For example, should a program that demonstrates significant positive effects over a relatively brief period of time be considered successful when the program was originally designed to influence behavior over a long period of time? What about a program that has a positive impact on only boys or only girls, even though it was designed to affect both? Can a program that significantly delays participants' sexual initiation but has no effect on their subsequent contraceptive use be considered effective? Readers should pay careful attention to specific results of each program evaluation.

Programs may have unmeasured positive effects. This review is narrowly focused on the effect certain programs for middle school-aged youth have on teen sexual activity, contraceptive use, and pregnancy. It could be that these programs have positive effects beyond these specific measures — building adolescent self-esteem or knowledge of HIV risks, for instance.

Programs can't do it all. Since teen pregnancy is rooted partly in popular culture and social values, it is unreasonable to expect that programs

alone can change forces of this size and power. Making true and lasting progress in preventing teen pregnancy will likely require a combination of community programs and broader efforts to influence values and popular culture. Of course, another reason why it is unfair to place the entire responsibility for solving the teen pregnancy problem on the backs of community programs is that many programs, even "effective" programs, often have only modest results, many are fragile and poorly-funded, and few teens are enrolled in these programs.

So, what to do? Those searching for a programmatic answer to the question "what works to prevent teen pregnancy" should pay close attention to the guidance provided in this publication, other National Campaign materials, and the growing body of high-quality research provided by other organizations.1 It is increasingly clear that a broad array of programs can be at least partially effective in delaying sex, improving contraceptive use, and preventing pregnancy among teens. The important news is that community-level interventions need not start their efforts from scratch. Communities should strongly consider putting in place those programs with the best evidence of success but resist holding unrealistic expectations for program success and the temptation to assume that programs alone can solve a problem as complex as teen pregnancy. Our hope is that No Time to Waste will provide some clear guidance to communities and encourage those concerned with adolescents to explore, develop, and evaluate new and innovative approaches to preventing teen pregnancy.

Sarah S. Brown Director, National Campaign to Prevent Teen Pregnancy

As noted in the acknowledgements, this publication was funded, in part, by the Centers for Disease Control and Prevention, as part of a continuing effort to publish and disseminate the latest research to help states and communities improve their teen pregnancy prevention efforts. Other national organizations — including Advocates for Youth (advocatesforyouth.org) and the National Organization on Adolescent Pregnancy, Parenting, and Prevention (NOAPPP.org) — have also received grants from the CDC for similar purposes. Readers interested in learning more are encouraged to visit their websites. For those interested in future relevant National Campaign materials, please visit teenpregnancy.org.

Introduction

Much reporting on teen pregnancy trends focuses primarily on adolescents aged 15–19 simply because less published information is available on younger teens. Yet available data make it clear that there is good reason to be equally concerned about sexual activity among middle school youth — those who are age 14 and younger. For instance, according to a recent report by the National Campaign to Prevent Teen Pregnancy (National Campaign to Prevent Teen Pregnancy, 2003):

- One in five teens report that they have had sex before age 15.
- Early sexual activity has been linked to a greater number of sexual partners over time and an increased risk of teen pregnancy and sexually transmitted diseases.
- Eighty-one percent of sexually experienced youth aged 12–14 wish they had waited longer to have sex.
- The younger a girl was the first time she had sex, the more likely it was to have been unwanted.

Recognizing the importance of reaching youth early — before they put themselves at risk for preg-

nancy, HIV, and other STDs — communities across the country have set up prevention programs that specifically serve middle school-aged youth. Some of these programs are profiled in this report.

With funding from the Centers for Disease Control and Prevention (CDC), the National Campaign to Prevent Teen Pregnancy has joined with Child Trends to assess the effect of programs on sexual activity, contraceptive use, and/or pregnancy among young teens. For the purposes of this report, the programs have been grouped in the following categories: Abstinence and Sex Education Programs, HIV/AIDS and other STD Education Programs, and Service Learning Programs. All programs described in this report have been carefully evaluated, and program evaluations must have met several scientific criteria. They must have:

- been completed in 1980 or later;
- been conducted in the United States or Canada;
- been targeted at teens in sixth through eighth grade and/or teens under age 15¹;
- used an experimental or quasi-experimental design²;
- 1 Programs that also served teens age 15 and older were included if at least 50 percent of program participants were age 14 or younger.
- 2 Experimental designs randomly assign study participants to intervention and control groups and then compare the two groups. Quasi-experimental designs do not randomly assign study participants to either group but do compare the intervention group with a comparison of youth with similar characteristics in a control group.

- had a sample size large enough to make comparisons between program and control groups³; and
- measured effects on sexual behavior or contraceptive behavior, and/or pregnancy.

While evaluations have shown that most of these programs had a positive effect on teen sexual behavior, some programs have not. The latter also have been included here so that readers can consider program characteristics that are promising and those that are not.

No Time to Waste: Programs to Reduce Teen Pregnancy Among Middle School-Aged Youth begins with a summary of what is known from the research about the sexual behaviors of teens age 14 and younger. This is followed by an overview of the types of programs described in the report, along with a list of key insights that emerged from the evaluations. The report then profiles 12 middle school programs that were evaluated using experimental or quasi-experimental designs.

These programs focused on delaying sexual initiation, reducing sexual activity among sexually experienced teens, improving the consistency and effectiveness of contraceptive use for pregnancy prevention, and/or increasing condom use for disease prevention. In many cases, the evaluations also measured knowledge, attitudes, and communication skills, which are believed to influence risk-taking behavior. However, the primary focus of this report is the influence of programs on adolescent behavior.

It is important to keep in mind that few pregnancy prevention programs for middle schoolers have actually been evaluated. And of those that have been studied, even fewer have used rigorous research designs. As a result, reliable information on the ability of programs to prevent risky sexual behavior among young adolescents is limited. Still, the information provided in this report can help to guide program providers, policy-makers, and funders in the selection of programs for their communities.

What the Research Shows

As noted earlier, despite concerns about sexual activity among young adolescents, there is relatively little published information on this topic (National Campaign to Prevent Teen Pregnancy, 2003). One primary reason is that most of the major data sets used to gather information on teen sexual behavior simply do not collect information about younger teens. Fortunately, new analyses of existing data sets that do include young teens have yielded some interesting findings that enhance our understanding about what younger teens are doing. For example:

Many young teens have had sexual intercourse. Recent nationally representative data analyses show that approximately one in five teens have had sexual intercourse before the age of 15 (National Campaign to Prevent Teen Pregnancy, 2003).

There are significant gender and racial/ethnic differences regarding the likelihood a teen will have sex before age 15. Boys (particularly Black and Hispanic boys) age 14 and younger are more likely to have had sex than girls the same age (National Campaign to Prevent Teen Pregnancy, 2003). In addition, 34 percent of African Americans report having had sex before age 15 compared to 19–21 percent of Hispanics and 14–16 percent of White teens in this age group (Bruckner & Bearman, 2003; Terry-Humen & Manlove, 2003).

Family socioeconomic status is associated with early sexual intercourse. Adolescents from families with higher incomes and higher educational levels are less likely to be sexually experienced than those from families with lower incomes and less education (Afexentiou & Hawley, 1997; Brewster, 1994; Lammers, Ireland, Resnick, & Blum, 2000; Miller, 1998; Santelli, Lowry, Brener, & Robin, 2000).

³ Program evaluations included in this report had 75 or more program and control group participants.

Adolescents living in two-parent families are less likely to engage in risky sexual behavior.

Teens living in two-parent families, especially with two biological parents, first have sex at a later age than those from single-parent homes (Afexentiou & Hawley, 1997; Meschke, Zweig, Barber, & Eccles, 2000; Moore, Morrison, & Glei, 1995; Santelli et al., 2000). This is due, in part, to higher household income and more parental monitoring in two-parent households.

Teens who have sex at an early age have more sexual partners over time. Compared to adolescents who delay having sex for the first time, teens who have sex at a younger age have more lifetime sexual partners (Finer, Darroch, & Singh, 1999; Shrier, Emans, Woods, & DuRant, 1996; Smith, 1997). In fact, a girl who had sex for the first time before age 14 was more than twice as likely to have multiple recent sexual partners than a girl who had sex for the first time when she was 16 or older (Santelli, Brener, Lowry, Bhatt, & Zabin, 1998). Teens who begin having sex early also are more likely to get pregnant and to give birth. (Manlove, Terry, Gitelson, Papillo, & Russell, 2000; Thornberry, Smith, & Howard, 1997).

Teens who have sex at an early age have low rates of contraceptive use. Sexually active young teens are less likely to use contraception than those who first have sex at an older age (Manning, Longmore, & Giordano, 2000; Mauldon & Luker, 1996; Santelli et al., 2000). A study of urban minority teenagers found that those who first had sex at age 16 or older were more likely to use condoms regularly than their younger sexually active counterparts (Smith, 1997).

Young, sexually active teens are more likely to have older partners and to be involved in coercive sexual relationships. Young adolescents who have sex, especially girls, are more likely than teens who delay having sex to have a partner who is several years older than they are (Ryan, Manlove, & Franzetta, 2003). This is problematic because teens with older sexual partners are less likely to use contraception and are more likely to become pregnant/cause a pregnancy than those who partner with someone their same age (Abma, Driscoll, & Moore, 1998; Darroch, Landry, & Oslak, 1994; Zavodny, 2001).

Early sexual experiences are often non-

voluntary. Many girls who have sex at a young age report that their first sexual experience was not voluntary (Abma et al., 1998). Indeed, 24 percent of teen girls who had sexual intercourse before age 14 report that their first sexual experience was nonvoluntary. Another study found that about half of non-voluntary intercourse among females (aged 18–22) occurred when they were younger than 14 years old (Moore, Nord, & Peterson, 1989). Nonvoluntary intercourse may also increase the risk of multiple partners, contraceptive failure, and adolescent pregnancy (Boyer & Fine, 1992; Laumann, Smith, Besharov, Gardiner, & Hoff, 1996; Roosa, Tein, Reinholtz, & Angelini, 1997; Stock, Bell, Boyer, & Connell, 1997).

Studies of pregnancy prevention programs that have been rigorously evaluated suggest that programs introduced in high school may provide too little information too late, especially for teens who are already in sexual relationships (Moore & Sugland, 1996). As discussed above, some racial and ethnic minorities, children in single-parent families, and children whose parents have low socioeconomic status are more likely to have sex before age 15. Programs designed to reach middle school-aged youth can address the needs of sexually inexperienced teens and help them delay sexual initiation, while also educating sexually experienced teens about delaying subsequent sexual experiences, negotiating sexual activity and contraceptive use with their partners, and methods to avoid pregnancy and STDs.

⁴ Note, however, that early sexual activity and having multiple partners may both be due to other background factors not measured in this study.

⁵ Note, however, that early sexual activity and contraceptive use may both be due to other background factors not measured in this study.

Overview of Three Types of Programs for Middle School-Aged Youth

The profiles in this report are grouped into three general categories: abstinence and sex education programs, HIV/AIDS and other STD education programs, and service learning programs.

Abstinence and Sex Education Programs.

There are seven programs in this category and four of them showed a positive effect on sexual activity and/or contraceptive use, at least for some populations of teens. The duration of the four programs that showed positive effects varied and included ten one-hour sessions (*McMaster Teen Program*, p. 18), a two-year program with ten mandatory sessions and eight voluntary group sessions (*PSI*, *Human Sexuality*, and *Health Screening*, p. 22), a three-year program with nineteen hours of sessions (*Draw the Line/Respect the Line*, p. 13), and two four-hour sessions held over two days (*Making a Difference!*, p. 26).

While settings varied slightly, all four of the programs occurred in classrooms for teens in sixth through eighth grades in middle schools and junior high schools. All of these effective programs included boys and girls. The majority of participants in Draw the Line/Respect the Line were Hispanic, the PSI Human Sexuality and Health Screening program primarily served African American teens, the McMaster Teen Program had mostly White participants, and Making a Difference! targeted African American middle school students.

All four of these programs emphasized abstinence, and one also provided information on contraception (*Draw the Line/Respect the Line*). Two of the programs had a positive effect on delaying sexual initiation: males in *Draw the Line/Respect the Line* were more likely to have remained abstinent by the end of the first and second school years of the program and females in *PSI Human Sexuality*

and Health Screening were less likely to have had first sex by the end of year one of the intervention. Two of the programs also showed positive effects on contraceptive use among sexually experienced teens: male participants in the McMaster Teen Program were more likely to have always used birth control at the 12-month follow-up and female participants in PSI Human Sexuality and Health Screening were more likely to have used contraception the last time they had sex. Making a Difference (p. 26) showed positive short-term effects (at the three-month evaluation) but had no long-term effects on delaying first sex, although program participants did report a higher frequency of condom use (at the 12-month evaluation). All of the effective programs in this category incorporated roleplaying to negotiate sexual activity, refusal skills, and/or contraceptive use.

Three other abstinence and sex education programs that were experimentally evaluated, but found to have no effects on sexual behavior and/or contraceptive use, are also included in this report: Postponing Sexual Involvement/Education Now and Babies Later (PSI/ENABL, p. 30), Healthy for Life, (p. 35) and Project SNAPP (Skills and kNowledge for AIDS and Pregnancy Prevention, p.33) had no effects on outcomes among teens. These profiles include evaluator insights on these results.

HIV/AIDS and Other STD Education

Programs. Three of the four programs in this category were effective for some populations. The programs varied in structure and length, but all included information on abstinence and contraception or condom use. *Making Proud Choices! A Safer-Sex Approach to HIV/STDs and Teen Pregnancy Prevention* (p. 42) was designed for sixth and seventh graders and consisted of two four-hour sessions on consecutive Saturdays. Designed for youth aged 9–15, *Focus on Kids* (p. 37) consisted of eight 1¹/₂-hour sessions and took place in recreation centers. *The Youth AIDS Prevention Program* (*YAPP*, p. 46) spanned two school years and consisted of two weeks of daily classroom sessions in

seventh grade, followed by one week of daily sessions in eighth grade. Most of the teens in these three effective programs were African American.

All three of the effective programs incorporated role-playing activities that allowed participants to practice negotiating refusal of sex and/or condom use. All three programs showed a positive impact on condom use, including greater levels of recent use (at the six-month follow-up of Focus on Kids), greater consistency of use (at the twelve-month follow-up of Making Proud Choices), and a greater likelihood of using condoms in combination with foam (immediately following the completion of YAPP). In addition, sexually active teens in Making Proud Choices had lower levels of recent sexual activity than teens in the control group 12 months after program completion. Program participants in YAPP were marginally more likely to report not having sex in the past 30 days compared to control group teens at the eighth grade follow-up. One additional HIV/AIDS education program found no effects on sexual behavior or contraceptive use and is included in this report: AIDS Risk Reduction Education and Skills Training (ARREST, p. 51) includes evaluator insights on why it was not effective.

Service learning programs. Reach for Health Community Youth Service Program (RFH-CYS) combined an in-school component with afterschool community volunteer experiences. This year-long program targeted seventh and eighth graders, and the majority of participants were African American. The evaluation found that program participants were more likely to remain abstinent than teens in a control group at the 24-month follow-up, and the additional non-experimental analyses suggested that the effects were stronger for teens who stayed in the program for two years than they were for those who were in it for only one year.

Key Insights from Evaluated Programs for Middle School-Aged Youth

Several key insights emerged from the evaluations of these programs targeted at middle schoolaged youth.

Both abstinence messages and safer sex messages are appropriate for younger teens. Because one in five teens are sexually experienced before age 15, sex education programs should provide information about the importance of abstaining from sex and, for those who are sexually active, the importance of using contraception consistently and correctly. All young teens need to learn about the benefits of abstinence as the best protection against pregnancy and sexually transmitted diseases. It is also true that the majority of teens in this age group have not had sex. But because some young teens will already have had sex or will still choose to have sex, they also need accurate information about how to do so as safely as possible. In fact, evaluations of the programs profiled in this report suggest that programs combining abstinence messages and "safer sex" messages can help delay first sex and improve contraceptive use among teens in this age group.

In the National Campaign's 2001 review, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, author Douglas Kirby notes that the most successful curricula-based programs have ten characteristics in common, including sufficient length to cover all information as well as activities to practice communication and refusal skills, (see box on p. 6).

Some programs seem more effective with certain populations of young teens than with others. For example, preliminary findings from *Draw the Line/Respect the Line* only demonstrated positive results for boys, while *PSI Human* Sexuality and Health Screening only showed positive

results for girls. Many of these program profiles summarize evaluators' analyses of why these differences emerged. As these programs are replicated and further evaluated, more will be learned about what works with particular populations.

Program intensity and length affect out-

comes. Middle school programs that ran for longer periods of time and that were more intensive had more enduring effects. One example is the Draw the Line/Respect the Line program, which ran for three years. Boys in the program were less likely to report ever having sex, and those who were sexually active were less likely to have had sex at the end of the first and second school years of the program. The differences between participants and control group members on these measures increased over the duration of the program. Several of the shorter programs profiled in this report have added booster sessions to help reinforce their messages and sustain their effectiveness over time. This is important because, as some program evaluators have suggested, it is especially difficult to sustain abstinence messages over time as teens are continually faced with media messages encouraging them to have sex.

One third of the experimentally evaluated programs profiled in this report showed no effects on teen sexual and contraceptive use behaviors, even in the short-term. Several other programs showed only short-term effects on behaviors. Evaluators suggest that programs did not work because they were generally too short in duration, and because they did not incorporate enough skill-building exercises.

Practice makes perfect. While giving teens accurate information about pregnancy and STD/HIV prevention is an important part of their sex education, helping them learn how to put that information into practice seems equally so. Some

Successful Programs...

- 1) focus on specific behavioral goals;
- 2) are based on theoretical approaches;
- 3) deliver clear messages about sexual activity and/or contraceptive use;
- provide basic information about risks associated with teen sexual activity and methods to avoid pregnancy or STDs;
- 5) address social pressures toward having sex;
- 6) provide activities to practice communication and refusal skills;
- incorporate multiple teaching methods and personalize information to individual needs;
- 8) are tailored to participants' age-level, culture, and level of sexual experience;
- are long enough to cover all information and activities; and
- provide appropriate training for teachers or peer leaders who are committed to the program.

Source: (Kirby, 2001)

of the middle school programs that had teens talk about issues and do role-playing around negotiation and refusal skills were particularly effective in reducing sexual risk-taking.

Stick to the program. Several evaluators stressed the importance of adhering to existing curriculum as it is written, even if some people find the topics sensitive. These programs showed positive outcomes on teen behavior using the curricula developed to achieve specific goals. Altering the content runs the risk of reducing the program's effectiveness.

Conclusion and Ideas for the Future

Given that, by the age of 15, nearly one in five children have already had sex, the middle school years represent a critical time for influencing young people's decisions about sex. So far, the evaluation research on the effects of programs specifically for young teens is encouraging, but many of the impacts are modest in magnitude and brief in duration. More information is needed on several fronts. For instance, we know little about how these programs would work with various populations and in different settings, or how specific program elements affect the behavior of teens. For instance, how important is the curriculum or the community service opportunity? Is there enough emphasis on role-playing and other participatory

activities? How long do these programs need to run in order to have an effect and then endure over time? Additional information on the costs of program implementation also would be helpful.

We know that young teens are facing tough decisions about sex and relationships. We need to equip them with information and skills to act wisely and safely. To that end, educators, parents, policymakers, and others who work with young teens can use the profiles that follow to set up programs that are known to have positive effects on teen sexual behaviors. In addition, all newly established programs should include a rigorous evaluation component in order to contribute further to our base of understanding about how programs for middle school-aged youth can help postpone sexual involvement and reduce teen pregnancy.

⁶ When suggesting a particular teen pregnancy prevention curriculum to a school district, it is important to become familiar with the curricula guidelines and requirements that are set by the state and the local district. The more closely aligned the objectives and content of a particular prevention curriculum is to the local and state guidelines, the more likely it is to be adopted.

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Program Profiles

In this section are descriptions ("profiles") of selected programs serving middle school-aged teens. All these programs have been carefully evaluated to assess their effects on sexual activity, contraceptive use, and/or pregnancy among young teens.

The profiles are divided into three categories: Abstinence and Sex Education Programs, HIV/ AIDS and other STD Education Programs, and Service Learning Programs. However, readers should keep in mind that these programs are not all singularly focused — for instance, some address STD and pregnancy prevention. Each profile begins with a brief overview of the program, followed by a more detailed program description and the evaluation findings. Most of the 12 programs described in this report showed positive results in the areas of teen sexual behavior, contraceptive use, and/or pregnancy rates — at least in the short term and for some populations. For those programs that did not show positive results, abbreviated profiles are included to serve as examples of approaches that appear less promising.

Finally, it is important to note that these profiles are based on program evaluations; therefore, they describe the specific circumstances (such as location, timeframe, number of participants, and

demographics) under which each program was assessed.

Abstinence and Sex Education Programs

Programs that changed participants' behavior

- 1. Draw the Line/Respect the Line
- 2. McMaster Teen Program
- 3. Postponing Sexual Involvement (PSI), Human Sexuality, and Health Screening Curriculum
- 4. Making a Difference! An Abstinence-Based Approach to HIV/STDs and Teen Pregnancy Prevention

Programs that did not change participants' behavior

- Postponing Sexual Involvement (PSI)/ Education Now and Babies Later (ENABL)
- Project SNAPP (Skills and kNowledge for AIDS and Pregnancy Prevention)
- 7. Healthy for Life

HIV/AIDS and other STD Education Programs

Programs that changed participants' behavior

8. Focus on Kids

- 9. Making Proud Choices! A Safer-Sex Approach to HIV/STDs and Teen Pregnancy Prevention
- 10. Youth AIDS Prevention Program (YAPP)

Programs that did not change participants' behavior

11. The AIDS Risk Reduction and Skills Training Program (ARREST)

Service Learning Programs

Programs that changed participants' behavior

12. Reach for Health Community Youth Service Learning (RFH-CYS)

Abstinence and Sex Education Programs

Draw the Line/Respect the Line (Overview)

Draw the Line/Respect the Line was a three-year, school-based sex education program for sixth, seventh, and eighth grade students held in three school districts in urban Northern California between 1997 and 1999. This program was primarily designed to help young adolescents postpone having sex. Increasing condom use was a secondary goal. The program used a 19-session curriculum

that taught youth how to establish and maintain limits regarding sexual behaviors.

Preliminary results from an experimental evaluation showed that at the end of seventh and eighth grade, boys (but not girls) in the program were less likely than those in the control group to report ever having sex, or to have had sexual intercourse within the past year.

Three curriculum guides are available for purchase — one each for grades six, seven, and eight. They can be purchased individually for \$21 or as a set for \$56.

INSIGHTS AFTER THE FACT

Key challenges

- In order for this program to be effective, it is critical that students receive all three years of it. This can be difficult when schools already have substantial time demands placed on them.
- *Draw the Line/Respect the Line* took longer to conduct in Special Education classroom settings because the pace of instruction was slowed to accommodate different learning levels.
- The program faced challenges with some multilingual classes. Although the materials were provided in English and Spanish, some youth were not completely adept with either language. The program used language "buddies" for these students to help translate instructions for the materials.
- Some communities may be less comfortable with the curriculum for the older teens because it includes more explicit information on STDs and other sensitive issues, and some communities may feel this content is not appropriate at the middle school level.

Lessons Learned

- The program seems to work best when sessions are held at least twice a week.
- The evaluation found *Draw the Line/Respect the Line* had a limited effect on girls. An important predictor of whether or not a girl has sex is related to the age of her partner. The program does not focus on how to set limits with an older partner.
- It is very important that facilitators be trained and comfortable with the program content. Using outside educators made delivering the program less burdensome for the classroom teacher; however, training classroom teachers increases the likelihood that the program will be continued.

SOURCE: DR. KARIN COYLE, CO-PRINCIPAL INVESTIGATOR, ETR ASSOCIATES

Draw the Line/Respect the Line

PROGRAM DESCRIPTION

Draw the Line/Respect the Line was a three-year classroom-based program that took place in three school districts in urban Northern California between 1997 and 1999. It served children in grades six through eight. Using group discussions, small group activities, and role playing, the program aimed to delay the initiation of sex in order to reduce the incidence of STDs, including HIV/AIDS, and pregnancy.

Type of Intervention

Draw the Line/Respect the Line included 19 class-room sessions. During the first year, sixth grade students participated in five lessons focused on using refusal skills in non-sexual situations. In the second year, seventh grade students had seven lessons that addressed setting sexual limits, understanding the consequences of unplanned sex, handling pressures regarding sexual intercourse, and practicing refusal skills. In the final year, eighth grade students received seven lessons on practicing refusal and interpersonal skills, and participated in activities regarding HIV/STD education.

The program used social cognitive theory and social inoculation theory based on the assumption that knowledge and constant skill practice can influence sexual risk-taking behaviors.

Population Served

Draw the Line/Respect the Line served youth in sixth, seventh, and eighth grades with an average age of 11.5. Program participants were 59 percent Latino, 17 percent White, and 16 percent Asian. Half of the participants were male and half were female.

Setting

The program was designed to be conducted in schools.

Goals

The program sought to encourage middle school-aged youth to delay having sexual intercourse. This abstinence-focused program tried to develop teens' interpersonal and intrapersonal skills so they could set sexual limits. Among sexually experienced teens, the program focused on reducing sexual activity and encouraging condom use.

Main Messages

The primary message conveyed through *Draw* the *Line/Respect the Line* was that postponing sexual activity during adolescence is the healthiest choice. Program sessions encouraged participants to discuss social and peer pressures to have sex, to set limits, to abstain from sexual intercourse, and to stay clear of risky situations. *Draw the Line/Respect the Line* also provided information on HIV, other STDs, and pregnancy prevention, as well as correct condom use.

Operation/Logistics

Length of program: Youth received 19 classroom-based sessions, each of which lasted 45–60 minutes. Year One (sixth grade) consisted of five classroom sessions; Year Two (seventh grade) consisted of seven classroom sessions; and Year Three (eighth grade) also consisted of seven classroom sessions.

Size of program: The evaluated program in northern California took place in 19 middle schools in three school districts. A total of 2,829 sixth graders were tracked over the three years.

Components of intervention: A variety of interactive teaching methods were used, including group discussions, role playing, stories, and games. The program materials were designed to provide information in a format that was interesting and engaging.

Staffing requirements: Program leaders were experienced health educators who received training on how to conduct *Draw the Line/Respect the Line* and administer session activities.

CURRICULUM

Each of the three *Draw the Line/Respect the Line* manuals (one for each grade level) begins with an introduction describing the importance of the program, an overview of the curriculum, and a description of the underlying principles that guided the program's development. Information is also provided for facilitators on how to use the manual and teach the sessions. The curriculum is available in English and Spanish.

The sixth grade curriculum includes the following:

- **Session 1** introduces the concept of what it means to "draw the line." Activities encourage youth to personalize this concept.
- **Session 2** builds on session 1. Participants identify strategies for communicating their message.
- **Session 3** builds on the previous sessions by having participants engage in role playing and communicate where they draw the line.
- **Session 4** highlights how to handle highpressure situations and use effective communication skills.
- **Session 5** discusses the role that friends play in respecting the line. Role play scenarios are used to practice showing respect for another person's limits.

The seventh grade curriculum includes the following:

- **Session 1** is an overview of what students have already learned about "drawing the line" and provides an overview of the seventh grade program. Activities focus on what makes it difficult to "draw the line" when placed in high-pressure situations.
- Session 2 focuses on the consequences of having sex.
- **Session 3** helps students identify ways to handle risky situations. Activities encourage students to become aware of situations that could lead to sex.

- **Session 4** uses role playing exercises to focus on "drawing the line" in risky sexual situations.
- Session 5 provides information on STDs, their symptoms, and ways to avoid transmission.

 Students learn that abstinence is the most effective method for preventing STDs and unwanted pregnancy. This session also emphasizes that students who do choose to have sex must always use a condom to reduce the risk of contracting an STD.
- **Session 6** addresses sexual pressure. Activities include a mock talk show and role playing to practice assisting friends in resisting sexual pressure.
- Session 7 has students participate in activities that review key steps for drawing the line and respecting the line.

The eighth grade curriculum includes the following:

- **Session 1** has students read and discuss a true story by a young woman with HIV about how her life has been affected. Students also create their own version of the *Draw the Line* logo based on their own lives.
- Session 2 provides information on how to prevent the spread of HIV and other STDs through a game show format. It emphasizes that abstaining from sex, for virgins and non-virgins alike, is the most effective way to avoid HIV and other STDs.
- **Session 3** discusses the challenges of sticking with personal limits.
- **Session 4** allows students to practice upholding their limits using role playing exercises.
- **Session 5** has a guest speaker share his or her experiences living with HIV/AIDS.
- **Session 6** discusses how to reduce the risk of HIV, STDs, and pregnancy. Students learn how to properly use condoms.
- Session 7 closes out the program by asking students to identify things that can help them maintain their limits.

EVALUATION

Type

Draw the Line/Respect the Line included an experimental random-assignment evaluation. Nineteen public middle schools from three urban school districts in Northern California were randomly assigned to either the Draw the Line/Respect the Line program or to the control group. The evaluation included 2,829 participants and control group members. The evaluation study was completed between spring 1997 and spring 1999. Students in 10 intervention schools received the Draw the Line/Respect the Line program and students in nine control-group schools received their school's regular HIV/sex education curriculum.

Components

Instruments and Frequency: Self-report surveys in English and Spanish were administered annually. The baseline survey was given in the sixth grade, and follow-up surveys were administered in the seventh grade (at 12-months) with a 91 percent retention rate, the eighth grade (at 24-months) with an 88 percent retention rate, and the ninth grade (at 36-months) with a 64 percent retention rate.

Outcomes measured: Participants were asked about a number of behaviors for the past twelve months: Sexual activity (including ever had sex), frequency of sexual intercourse, number of sexual partners, "coercive behaviors", and "unwanted sexual advances" were measured at baseline and at all three follow-up points. Other outcomes measured included condom-related knowledge, attitudes toward abstaining from sex, perceptions of peer norms supporting sex, setting sexual limits, and avoiding potentially risky sexual situations.

Findings

The final evaluation results are forthcoming (Coyle et al., in press); however, preliminary find-

ings suggest that the program was more effective for boys than for girls (Coyle et al., 2000). At the end of seventh and eighth grade, boys in the program were less likely to have initiated sexual intercourse or to have had sex in the past 12 months compared to boys in the control group (Coyle, et al., 2000). There were no program effects for girls at the end of the seventh or eighth grade program years on either sexual initiation or sexual intercourse in the past year (Coyle, et al., 2000).

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Master Teen Program (Overview)

The McMaster Teen Program was a sex education program serving seventh and eighth grade middle school students. Administered as part of the school curriculum, this 10-session program was carried out in 11 schools in Hamilton, Ontario in 1982. The goals of the McMaster Teen Program were to delay first sex and to reduce unintended teen pregnancy. It used a coeducational, small-group approach and included four components: 1) providing information on adolescent reproductive health; 2) facilitating communication around sexual decisions; 3) developing problem-solving skills; and 4) practicing decision-making skills.

An experimental evaluation conducted one year after the program ended found that boys in the program were more likely to report always using contraception than boys in the control group. However, this effect was no longer apparent at a four-year follow-up. The program evaluation did not show an effect on initiating first sex among boys, nor did it affect timing of first sex, contraceptive use, or pregnancy rates among girls.

The program costs approximately \$280 (Canadian dollars) per student. Training for the tutors is approximately \$1,100 (Canadian dollars).

INSIGHTS AFTER THE FACT

Key challenges

- Obtaining approval from the school board to institute the program was a primary hurdle. After several months of negotiation, the program was allowed with the stipulation that it not provide information on contraception. This reduced the program from 14 to 10 weeks. Parental consent was also required.
- Designing the questionnaires to be used in the evaluation was a challenge. Ultimately, they were written so that students only answered questions about sexual behavior that tracked with their level of experience. Once they responded "no" to a behavior, they stopped filling out the questionnaire.

Lessons Learned

- Several revisions to the curriculum would be useful, including:
 - Adding booster sessions one to two years after the program ends to reinforce the program's messages.
 - Adding a parental component to teach parents how to talk with their children about sex.
 - Enhancing the confidentiality aspects of the program, such as the anonymous question box.
 - Continuing to incorporate problemsolving activities.

SOURCE: DR. ALBA MITCHELL-DICENSO, RN, PROGRAM EVALUATOR, MCMASTER UNIVERSITY

The McMaster Teen Program

PROGRAM DESCRIPTION

The *McMaster Teen Program* was a 10-session sex education program for seventh and eighth grade middle school students. Administered as part of the school curriculum, the program was carried out in 1982 over a six to eight week period in 11 schools in Hamilton, Ontario. The goals of the program were to delay first sex and reduce teen pregnancy.

Type of Intervention

"Tutors" (session leaders) led small groups in activities focused on adolescent sexuality.

Population Served

The program served seventh and eighth grade students between the ages of 11 and 16. Most of the participants were White, and approximately 75 percent of the students lived with both parents and spoke English in the home. Slightly more than half (51 percent) of the participants were female.

Setting

The *McMaster Teen Program* was a school-based program, and students met in co-educational groups of six to ten.

Goals

The program was intended to delay first sex and prevent pregnancy by improving problem-solving skills and encouraging responsible decision-making about sex.

Main Messages

Teens were encouraged to take responsibility for decisions regarding sex. They were encouraged to delay having sex, but if they were sexually active, they were instructed to act responsibly (e.g. to show respect for their partner). The board of education did not allow information on contraception to be included in the program.

Implementation/Logistics

Length of program: The McMaster Teen Program ran for six to eight weeks and consisted of 10 one-hour sessions.

Size of program: A total of 2,111 students from 11 public schools participated in the program.

Components of intervention: The program used role playing to help teens practice problem-solving and sexual decision-making skills. There were four program components: 1) providing information on reproductive health, adolescent development, sex, and relationships; 2) facilitating communication about sexual choices and behaviors; 3) helping the students develop problem-solving and decision-making skills regarding sexual behavior; and 4) providing opportunities for students to practice decision-making about sex.

Staffing requirements: There was one program coordinator for all the schools and 63 tutors for the 272 small groups. Tutors were nurses or teachers, all of whom received 40 hours of training on sex education, the role of a small group facilitator, and problem-based learning. The program coordinator maintained regular contact with each tutor.

CURRICULUM1

Students receive a handbook that includes articles, exercises, and activities to be completed before small-group meetings. Eight topics are covered during the program:

- Problem-solving and decision-making.
 Participants learn how to apply a six-step problem-solving and decision-making process.
- 2. **Puberty.** Teens discuss physical and emotional changes around puberty, as well as myths, selfimage, and peer pressure.
- Gender roles and the role of the media. Small groups discuss how the media portrays males and females individually and in relationships.

¹ The original curriculum for the McMaster Teen Program was revised in 1987.

Students assess the realism of such portrayals and clarify their own personal values about gender roles.

- 4. **Relationships.** The participants discuss communication, honesty, responsibility, peer pressure, self-esteem, and breaking-up in the context of dating relationships.
- Peer Pressure. Youth define peer pressure, discuss why people respond to peer pressure, and consider ways to deal with it.
- 6. **Intimacy.** Youth address types of intimacy found within relationships, consequences of sexual activity, gender roles, and communication.
- 7. **Teenage pregnancy and parenting.** Small groups discuss the risks and consequences of teen pregnancy as well as the responsibilities and challenges of parenting.
- 8. **AIDS.** Students learn the symptoms of infection, how the virus is transmitted, and effective prevention methods. The prevention methods discussed include abstinence and safe-sex practices.¹

The program uses an anonymous question box to encourage participants to be open about their concerns and questions. Students write down any questions they have, put them in a box, and then decide as a group which questions to discuss.

EVALUATION

Type

The *McMaster Teen Program* used an experimental design with random assignment and a four-year follow-up. Students in 11 schools (2,111) were assigned to the program. Students in 10 schools (1,263) were assigned to the control group, and received their school's usual sex education curriculum.

Components

Instruments and frequency: Students completed questionnaires at the start of the program, six

weeks after the program ended, and then annually up to four years after the program began.

Outcomes measured: Students completed three questionnaires each time: a locus of control measure (designed to measure student improvement over time in decision-making skills and problem solving skills), a demographic questionnaire, and a six-item private ballot questionnaire. The private ballot questionnaire included items about sexual behavior.

The private ballot questionnaire included the following five questions. Students only answered an item if they responded "yes" to the previous item.

- 1. Have you ever gone around (hung around) with a special boy/girl?
- 2. The following are some ways that people show affection: 1) holding hands; 2) hugging; 3) kissing; 4) necking; 5) petting. Have you ever shared your affection with a special friend in any of these ways?
- 3. Sexual intercourse occurs when a boy's penis goes into a girl's vagina. Have you ever had sexual intercourse?
- 4. The following are methods used to avoid pregnancy: the pill, the IUD (intrauterine device), the diaphragm, condom, foam or jelly, and natural family planning. How often do you/your partner use any of these birth control methods? Check the one descriptor below which is nearest to the truth: always, frequently, rarely, never.
- 5. For females, have you ever been pregnant?

Findings

Program effects were examined for both boys and girls. At the one-year follow-up, sexually active boys in the program group were more likely to report always using contraception than were boys in the control group. However, this effect diminished over time, and no differences existed between the program and control groups by the four-year follow-up. The program had no effect for boys on

¹ The original curriculum for the McMaster Teen Program (developed in 1982) was revised in 1987.

first sex. For girls, the program seemed to have no effects on delaying first sex, contraceptive use, or pregnancy rates.

The program evaluators suggested that the limited effects may be because the program was short. Also, information on contraception was not included in the program because the Board of Education would not allow it. Participants requesting such information were referred to the school nurse. In the publication *Emerging Answers*, author Douglas Kirby (2001) also suggested that the program content did not differ significantly from the typical sex education curriculum received by the control group.

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Postponing Sexual Involvement, Human Sexuality, and Health Screening Curriculum (PSI) (Overview)¹

Postponing Sexual Involvement, Human Sexuality, and Health Screening Curriculum (PSI) was a school-based program for seventh and eighth grade students in six schools in Washington, DC. This two-year abstinence-focused program tried to help students delay first sex. For youth who were already sexually active, PSI encouraged them to reduce sexual activity and to use contraception.

The program included three sessions on reproductive health and five sessions using the *PSI* curriculum, each of which lasted 45 minutes. It also used a health risk assessment questionnaire and a variety of educational activities.

An experimental evaluation of *PSI* found that girls in the program were more likely to have delayed first sex or to have used contraception at most recent sex than girls in the control group. Although boys in the program had higher knowledge levels and more positive attitudes about postponing childbearing, the program had no effect on their sexual activity or contraceptive use.

The *PSI* two-day training series cost \$500 plus travel, hotel, and meal expenses for the trainer. *Postponing Sexual Involvement: An Educational Series for Young Teens*, the curriculum manual for the *PSI* program (that includes a Leader's Guide and video) costs \$149. The Training Teen Leaders program costs \$200 and includes a detailed handbook for training students in grades 10–12 and five Teen Leader Survival Guides (additional guides cost \$12.95 each).

¹ There is no "Insights After the Fact" section in this profile because it was not possible to interview an evaluator from this program.

Postponing Sexual Involvement, Human Sexuality, and Health Screening Curriculum

PROGRAM DESCRIPTION

The Postponing Sexual Involvement, Human Sexuality, and Health Screening Curriculum (PSI) was carried out in six Washington, DC junior high schools in 1996 and 1997. It used several teaching methods including group discussions, small group activities, videos, and role playing to encourage youth to abstain from early sexual activity. The program aimed to help youth build knowledge and skills to make appropriate decisions about sex.

Type of Intervention

PSI was a two-year program. During the first year, seventh grade students participated in three classroom sessions focused on reproductive health issues, followed by a five-session PSI curriculum taught by peer leaders recruited from local high schools. Each session lasted 45 minutes. The program also had participants complete a health risk assessment questionnaire, and those who were identified to be "high risk" received individual interviews with program facilitators. During the second year, the students (then eighth graders) repeated the three reproductive health sessions from the previous year and participated in activities that reinforced the abstinence message. These activities included an eighth grade assembly on STDs and small informal group discussions on eight topics such as gang violence, personal hygiene, teen pregnancy, and drug abuse.

Population Served

PSI served inner city youth in the seventh and eighth grades. The average age of participants was 12.8. Approximately half of the participants (52 percent) were female and 84 percent were African American. Sixty-three percent of participants were from low-income families.

Setting

PSI was designed for a classroom setting during school hours.

Goals

PSI sought to delay first sex among middle school-aged youth. It also aimed to reduce sexual activity by youth who were already having sex and encouraged them to use contraception.

Main Messages

The primary message of *PSI* was that adolescents can and should postpone sexual activity. Program sessions helped participants consider peer pressures to have sex and practice skills for resisting such pressures.

Operation/Logistics

Length of program: Year One of PSI consisted of eight weekly classroom sessions, each of which lasted about 45 minutes. Year Two included three classroom sessions and eight voluntary group discussions held during lunch or a free period.

Size of program: The evaluated program took place in six junior high schools. Three schools offered the program and three served as control schools. A total of 522 boys and girls participated during the first year and 459 participated during the second year.

Components of program: PSI consisted of three components: 1) a series of reproductive health sessions; 2) a five-session PSI curriculum delivered by peer leaders recruited from nearby high schools; and 3) a health risk assessment questionnaire, which allowed project facilitators to identify the most high-risk youth and provide one-on-one intervention.

Staffing requirements: Program leaders were adults who were trained on how to conduct *PSI*. Group leaders, most of whom had prior experience teaching sex education classes, received two days of training. *PSI* also used teen leaders, who were tenth and eleventh graders, to do some of the presentations. They participated in a 30-hour training over four days, along with monthly after-school meetings.

CURRICULUM

The *PSI* curriculum includes a leader's manual and a video. The manual's introduction explains the goal of *PSI* and tips for success. The manual has detailed plans for each of the five sessions, which address the following areas:

- Session 1 focuses on the risks of early sexual involvement and has participants explore why some teens choose to have sex and others decide to wait. Activities allow youth to consider the consequences of sexual involvement and to identify alternatives.
- Session 2 addresses social pressures that lead to early sexual involvement. Through the use of video segments and media advertisements, youth become more aware of these pressures and discuss effective ways to resist them.
- Session 3 helps teens identify peer pressures and determine their own sexual limits. This session uses video vignettes, and youth participate in activities designed to help them set limits on physical affection.
- **Session 4** helps teens continue practicing how to resist pressures to have sex.
- **Session 5** summarizes the information from previous sessions using a game show format.

At the end of the manual are a variety of exercises that can be used to reinforce the skills taught in the sessions.

EVALUATION

Type

Six schools were matched on racial/ethnic composition and seventh grade class size to form three pairs of schools. The schools in each pair were randomly assigned to either the *PSI* program or to the control group. In the seventh grade, 262 program participants received the intervention and 260 teens were in the control group.

Components

Instruments and frequency: Self-administered questionnaires, available in English and Spanish, were administered at baseline, at the end of the seventh grade, and at the beginning and end of the eighth grade. Also, a risk assessment questionnaire measuring health (including physical fitness and depression), risk behaviors, academic performance, and social support was administered before the follow-up survey at the end of seventh grade.

Outcomes measured: Virginity status and contraceptive use at most recent sex were measured at all four assessments. Also included were measures of intentions to have sex in the next six months, perceptions of peer sexual activity, sex refusal skills, attitudes about postponing sex and delaying child-bearing, knowledge about contraception and reproductive health services for adolescents, and communication with parents and partners.

Findings

Sexually active girls in the program were more likely to use contraception at last sex than were girls in the control group. In addition, girls in the program were twice as likely to delay sex than those in the control group at the end of the seventh grade program and at the beginning of eighth grade. There were no significant differences for girls at the end of eighth grade.

Among sexually experienced teens, girls in the program group were three to seven times more likely than girls in the control group to report using some form of contraception the last time they had sex. This was the case at the end of seventh grade and at the beginning and end of eighth grade.

At the end of the seventh grade program only, female participants had lower expectations of sexual activity in the next six months and lower perceptions of peer sexual activity than did females in the control group. Female participants also were more likely to report that they would be able to refuse sex with a boyfriend if they did not feel ready, and they had a greater knowledge of reproductive health

services than the control group at the end of eighth grade. The program did not have any significant effects for females regarding refusal of sex with a stranger, attitudes about delaying sexual initiation or childbearing, or contraceptive knowledge.

No significant program effects were found at any of the measurement points for boys regarding virginity status or contraceptive use at most recent sex. Boys in the program had higher contraceptive knowledge (at all three measurement points) and more positive attitudes toward postponing childbearing (at the end of seventh grade and beginning of the eighth grade) than did boys in the control group. At the end of seventh grade only, males in the program were more likely to report that the majority of boys their age were not having sex. No significant program effects were found at any time regarding boys' refusal skills, attitudes about delaying sex, or parent or girlfriend communication.

Program evaluators suggested that the brief duration of the program and the lack of opportunity to reinforce assertiveness and communication skills could explain why program effects were minimal regarding perceptions of peer sexual experience, sexual activity expectations, sex refusal skills, and communication with either parents or boy/girlfriends (Aarons, Jenkins, Raine, & El-Khorazaty, 2000). Evaluators also hypothesized that the reproductive health education and counseling activities of the facilitators could be responsible for the positive program effects on contraceptive knowledge for boys and contraceptive use at last sex for girls.

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Making a Difference! An Abstinence-Based Approach to HIV/STD and Teen Pregnancy Prevention (Overview)

Making a Difference! was a community-based program for sixth and seventh grade African American boys and girls. It focused only on abstinence (not contraception) for preventing HIV, other sexually transmitted diseases (STDs), and pregnancy. Making a Difference! was held in two four-hour sessions in three Philadelphia middle schools. (The program could also be taught in eight one-hour sessions.)

An experimental evaluation found that, three months after finishing *Making a Difference!*, program participants who were virgins at the start of the program were less likely to have had sexual intercourse than virgins in the control group. Twelve months after the program ended, the likelihood of having had sexual intercourse did not differ between participants and control group members. However, program participants did report a higher frequency of condom use. An experimental, random-assignment evaluation of *Making a Difference!* is underway with Latino teens in Philadelphia to test whether the program is effective with this population.

Participants received \$100 (\$40 for completing the program and \$60 for participating in the evaluation). The curriculum can be purchased for \$100, and videos are available for an additional fee. Training costs are not available.

INSIGHTS AFTER THE FACT

Key challenges

- Recognizing that *Making a Difference!* was a short-term program, steps were taken to try and sustain its effects over time. To that end, a project called *Promoting Health Among Teens (PHAT)* provided a booster session (six weeks or three months after *Making a Difference!* ended), and six issues of a newsletter reinforced the program's messages. *PHAT* is following the teens for 24 months to determine whether it has any effect.
- It is important to ensure that facilitators adhere to the curriculum as it is written and not try to modify it in any way.

Lessons Learned

- In order to secure the community's support for Making a Difference!, program directors had to make sure adults understood that teens were at risk for HIV/STDs and unintended pregnancy. Once this was clear, the community became very involved in the program.
- The evaluation results suggest that intensive, culturally-appropriate approaches that are based on theory can reduce some risky sexual behaviors among inner-city African American adolescents.

Source: Dr. John Jemmott, University of Pennsylvania , Director, Center for Health Behavior & Community Research. Note: Dr. Jemmott commented on *Making a Difference!* and *Making Proud Choices!*

Making a Difference! An Abstinence-Based Approach to HIV/STD and Teen Pregnancy Prevention (Detailed Description)

PROGRAM DESCRIPTION

Making a Difference! taught African American middle school students that abstinence is the best way to prevent HIV/STD and pregnancy.

Type of Intervention

Teens were assigned to groups of six to eight participants. Each group was led by two peer facilitators or one adult facilitator. They watched videos and participated in discussions, role playing, and other communication exercises. The youth received a stipend for participating in the program and for completing evaluation surveys before *Making a Difference!* began and at regular intervals after it ended.

Population Served

The studied group consisted of low-income African American adolescents in sixth and seventh grade. Slightly more than half (53 percent) were female and they ranged in age from 11 to 13, with an average age of 11.8.

Setting

Making a Difference! was located in three Philadelphia middle schools in low-income communities.

Goals

The goal of *Making a Difference!* was to help boys and girls develop positive attitudes about abstinence and delay first intercourse for those who were virgins. It was also designed to teach teens about prevention of HIV/STDs and unintended pregnancy by reducing the incidence of risky sexual behaviors.

Main Messages

Making a Difference! stressed that abstinence is the only certain way to prevent HIV transmission and pregnancy. It also emphasized that teens should have pride in themselves and their community, and that the decisions they make about sex today can affect their futures.

Operation/Logistics

Length of program: Making a Difference! was held over two days, with each session lasting four hours. (It also could work as eight one-hour sessions.)

Size of program: A total of 215 youth participated.

Components of intervention: The program had four components:

- Helping teens in the program identify their goals and consider how having sex might prevent them from achieving those goals;
- Increasing understanding about the mechanisms of HIV transmission and unintended pregnancy;
- 3. Discussing attitudes towards abstinence, HIV/STDs, and pregnancy; and
- 4. Enhancing teens' ability to confidently communicate their desire to remain abstinent.

Staffing requirements: Each group had one adult facilitator or two peer facilitators, all of whom were African American. All adult facilitators had prior experience working with youth, and peer facilitators were students from Philadelphia high schools. Adult facilitators received two and a half days of training. The peer facilitators received three days of training on small-group facilitation and leadership and four days of training on how to run the program. A trainer observed the small groups to ensure that the program operated correctly.

CURRICULUM

The curriculum for *Making A Difference!* includes eight lessons:

■ Session 1 "Getting to Know You, and Steps to Making Your Dreams Come True" provides an overview of the program and asks participants to devise "group rules" to govern the sessions. It

- also includes discussions about unintended pregnancy, STDs, and HIV.
- Session 2 "Understanding Adolescent Sexuality and Abstinence" examines some of the reasons why teens have sex; discusses the physical and emotional issues associated with puberty; and reviews the benefits of abstinence. It uses a video called "What Kids Want to Know about Sex and Growing Up."
- Session 3 "The Consequences of Sex: HIV Infection" examines the possible outcomes of risky sexual behavior, focusing primarily on HIV. Activities include watching the video "Time Out," which explains HIV transmission, and discussing how various behaviors can increase one's risk of contracting HIV. Groups also play a trivia game called "AIDS Basketball," where teens accumulate points by answering questions correctly.
- Session 4 "Attitudes, Beliefs, and Giving Advice about HIV/STDs and Abstinence" focuses on self-esteem and the benefits of abstinence.

 Through role playing activities, teens learn how to give advice to peers about resisting sex and remaining abstinent.
- Session 5 "The Consequences of Sex: STD Infection" presents information about STDs through various activities. In "The Transmission Game," for example, teens learn how STDs are transmitted. Another game teaches participants how to negotiate risky sexual situations. A video clip called "Jesse" is viewed.
- Session 6 "The Consequences of Sex:

 Pregnancy" explains how sex can lead to unintended pregnancy. The session uses role playing to show teens how they can resist pressure to have sex. A video called "The Truth about Sex" is used to prompt further discussion about pregnancy, STDs, and HIV.
- Session 7 "Responding to Peer and Partner Pressure" explores how peer pressure affects decisions about sex. Youth discuss ways to respond to peer pressure and role playing activities pro-

- vide an opportunity to practice those skills.
- Session 8 "Role Plays: Refusal and Negotiation Skills" gives the boys and girls additional opportunities to practice refusing sexual activity. The session emphasizes why abstinence is a wise choice and how to negotiate for it. The primary activity is role playing with a peer.

EVALUATION

Type

The evaluation used a random assignment experimental design. It tested whether youth in *Making a Difference!* would report lower levels of sexual intercourse than members of the control group. The control group received a two-day, four-hour intervention on general health promotion. Approximately 93 percent of the teens participated in the 12-month follow-up.

Components

Instruments and frequency: The teens completed questionnaires prior to the program, after it ended, and at three-, six-, and 12-month intervals.

Outcomes measured: The primary outcomes measured at each follow-up (three-, six- and twelve-months) were sexual behavior and condom use (in the past three-months):

- sexual intercourse (yes vs. no)
- frequency of sex (number of days of intercourse)
- consistency of condom use (always used a condom during intercourse)
- frequency of condom use (rated on a scale of one [never] to five [always])
- unprotected sexual intercourse (yes vs. no)
- frequency of unprotected intercourse (number of days of intercourse when a condom was not used).

Findings

At the three-month follow-up, only 2.9 percent of program participants who were virgins at the

start of the program reported having sex for the first time compared with 10.3 percent of the control group members who were virgins at the start of the program. Twelve months after the program ended, participants in *Making a Difference!* reported a higher frequency of condom use than control group members (3.9 vs. 3.2 on the one to five scale). However, program participants and control group members did not differ on the other measures of sexual behavior and contraceptive use 12 months after the program ended. For example, there was no difference in the likelihood of having had sexual intercourse between participants and control group members.

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Postponing Sexual Involvement/Education Now and Babies Later (PSI/ENABL)¹

** Experimentally Evaluated Program That Did Not Affect Teen Sexual Behavior **

PROGRAM DESCRIPTION

Postponing Sexual Involvement/Education Now and Babies Later (PSI/ENABL) was an abstinence-based program for young teens. It used school forums and community activities to encourage youth to postpone sexual activity.

Type of Intervention

The Postponing Sexual Involvement (PSI)/Education Now and Babies Later (ENABL)
Program was a school-based and/or community-based after-school program for adolescents aged 12–14. The goal of this abstinence-focused program was to postpone sexual involvement. The PSI/ENABL program utilized the PSI curriculum that was developed in Atlanta for a school-based program. The PSI curriculum consisted of five sessions that lasted 45–60 minutes each and was implemented during after-school hours. ENABL was a statewide media outreach effort that included flyer distribution, a media campaign, assemblies, rallies, and fairs that sent positive messages about postponing sexual involvement.

The curriculum was based on three guiding educational principles: experiential learning, which involved teens through an interactive approach; providing a single, consistent message of postponing sexual involvement; and providing repetition and reinforcement of messages and skills learned in the programs.

Population Served

The *PSI/ENABL* program was implemented with an ethnically diverse group of teen males and females. Youth recruited from community-based agencies were more likely to be Asian or Pacific Islander (47–52 percent) and Hispanic (20 per-

cent). Nearly three percent of participants were Black and 5–10 percent were White. The participants' ages ranged from 12 to14 years. Youth in both the intervention and control groups were required to receive instruction in human sexuality before participating in *PSI*, although not all participants took part in the same lessons.

Setting

The *PSI/ENABL* program was a statewide initiative to reduce teenage pregnancy in California. Twenty-eight organizations, including school districts, health departments, and community-based organizations implemented the *PSI/ENABL* program in 17 school-based and community-based settings. The *ENABL* component of the program added media outreach activities. Program sites were selected because they provided services to communities with high teen birth rates.

Goals

The primary goal of *PSI/ENABL* was to delay the onset of sexual intercourse among middle school-aged youth. This abstinence-focused program sought to promote healthy alternatives to sexual activity. Among sexually experienced teens, the program goals were to reduce sexual activity and to encourage contraceptive use.

Main Message

The primary message conveyed through the *PSI/ENABL* program was that it is possible for adolescents to postpone sexual activity. The program was designed to help equip young people with the skills to resist pressures to become sexually active. Program sessions involved participants in thinking through and discussing the many social and peer pressures to become sexually experienced. Participants were then guided through a series of activities that allowed them to practice utilizing skills to resist these pressures.

Operation/Logistics

Length of program: PSI consisted of five sessions, each lasting 45 to 60 minutes. The evaluation of

¹ This profile of PSI/ENABL is brief because the evaluation found that the program did not affect sexual behavior among teens.

the *PSI/ENABL* program was based on the fivesession *PSI* program and the *ENABL* initiative.

Components of intervention: The intervention was made up of two distinct components:

- *PSI:* a five-session series focused specifically on helping young people delay sexual involvement. Session topics included risks of early sexual involvement, peer pressure, determining sexual limits, and resisting the pressure to engage in sex. This unit included a supplementary video.
- *ENABL*: a statewide media outreach effort that included flyer distribution, a media campaign, assemblies, rallies, and fairs that sent positive messages about postponing sexual involvement.

Staffing requirements: Intervention leaders were primarily adults who received training on how to implement the *PSI* program and effectively deliver the curriculum activities. A very small portion of programs utilized peer leaders who were recruited from 11th and 12th grade. Group leaders received two days of training and practice on how to operate the program. Most leaders belonged to organizations that commonly dealt with sexual issues and/or had taught sex education in the classroom.

EVALUATION

Type

The *PSI/ENABL* program utilized three levels of random assignment to evaluate the effectiveness of the program. The evaluation was conducted in California among 10,600 youth. Half of these teens received the intervention and half served as the control group. The evaluation randomly assigned youth from community-based agencies with after-school programs to the intervention or control group. Teens filled out a self-report survey at baseline and at a 17-month follow-up period. A final sample of 7,340 youth completed the baseline and follow-up surveys.

The surveys included several questions aimed at measuring whether the student became sexually active during the evaluation period or, if already sexually experienced, whether the student reduced the number of sexual partners or the frequency of sexual experiences. Additional questions measured whether the student had become pregnant and/or contracted a sexually transmitted disease. Other outcomes such as beliefs, attitudes, and intentions that might mediate the initiation of sexual intercourse were also measured.

Findings

There were no significant differences on any of the mediating variables, behavioral intentions, or measures of sexual and contraceptive behaviors among students in the treatment group compared with the control group at the 17-month follow-up period to the study.

Why no effects?

The evaluators suggested that the main reasons the program did not have the intended effects was that the five-session intervention was too short, that developing a program to help delay sexual initiation requires more intensive sessions, and that the curriculum did not provide an adequate number of skill-building sessions to provide teens with a chance to practice refusal skills (Kirby, Korpi, Barth, & Cagampang, 1997).

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Project SNAPP¹

** Experimentally Evaluated Program That Did Not Affect Teen Sexual Behavior**

PROGRAM DESCRIPTION

Project SNAPP (Skills and KNowledge for AIDS and Pregnancy Prevention) was a pregnancy and AIDS prevention program for middle school students in 102 classrooms in six middle schools in Los Angeles, California. The program was designed to help youth delay sexual activity by building their knowledge and communication skills.

Type of Intervention

Seventh grade students attended eight sessions of *Project SNAPP*. They practiced refusal skills for situations where they felt pressured to have sex and/or unprotected sex. They also heard from peer educators — 70 percent of whom were either teen mothers or HIV positive — about the importance of avoiding risky sexual behaviors.

Population Served

The program was designed for seventh grade students. The program served 1,657 students — 46 percent boys and 54 percent girls. The majority were Hispanic (64 percent), less than 10 percent were White or African American, and 13 percent were Asian. The majority (85 percent) spoke another language in addition to English.

Setting

Project SNAPP was held in the classroom during the school day.

Goals

Project SNAPP aimed to prevent HIV/AIDS and pregnancy among youth. It sought to increase condom use among youth who were sexually active, increase students' knowledge about the risks of sex, and encourage sexually active students to have less sex and fewer partners, and to avoid sex without contraception.

Main Messages

Project SNAPP stressed that students should delay first sex until they felt ready and that students who were sexually active should use condoms consistently.

Operation/Logistics

Length of program: This two-week program was held during the school day in eight sessions.

Staffing requirements: In addition to the class-room teacher, there were 10 peer educators who received extensive training (50 hours before the start of the program).

EVALUATION

Type

Project SNAPP was evaluated using an experimental design: classrooms in six middle schools were randomly assigned either to the SNAPP program, or to a control group, where they received lecture-style instruction. At baseline the two groups did not differ significantly. All seventh-grade students completed a confidential questionnaire before the first session and follow-up surveys five and 17 months later.

Findings

The evaluation questionnaire tested teens' knowledge about HIV/AIDS prevention, perceptions of condoms, condom use intention, and actual condom use. The evaluation also asked about timing of first sex, sexual activity patterns, and contraceptive use and trends.

At the five- and 17-month follow-ups there were few significant differences between the program and control groups. There were no significant differences in delaying first sex or in increased condom or birth control pill use at last sex among those who were sexually active. No differences emerged between the program and control groups regarding frequency of sex, number of partners, incidences of unwanted sex, or use of alcohol or other drugs prior to last sex.

¹ This profile of *Project SNAPP* is brief because the evaluation found that the program did not affect sexual behavior among teens.

One unexpected outcome appeared at the 17-month follow-up. The percentage of students who reported using birth control pills the last time they had sex was lower in the program group than in the control group (23.7 percent vs. 35.1 percent).

Why no effects?

Evaluators noted a few factors that may have contributed to the program's lack of success. First, the program lasted only two weeks, which may not have provided enough time for the messages and activities to influence the students. Second, the fact that some of the peer educators were teen mothers may have unintentionally "glamoriz[ed] being a teen mother" (Kirby, Korpi, Adivi, & Weissman, 1997).

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Healthy for Life1

** Experimentally Evaluated Program
That Did Not Affect Teen Sexual
Behavior**

PROGRAM DESCRIPTION

Healthy for Life was a program offered to students in 21 middle schools in Wisconsin. It was designed to minimize risks associated with alcohol and other drug use and sex. It also addressed nutrition issues.

Type of Intervention

The program included an in-school component in combination with peer leadership, family, communication, and community activities. Two versions were offered: one took place over a 12-week period during the seventh grade school year (the "intensive" program); the other took place in fourweek components across the sixth, seventh, and eighth grade years (the "age appropriate" program). In the second version, topic areas were broken into age appropriate categories and administered in sixth, seventh, or eighth grade. Thus, the material presented was considered appropriate for the gradelevel receiving the material.

Healthy for Life was designed using a social influence model, which views health behaviors in the context of social interactions. This approach hypothesizes that adolescents make health behavior choices based on the meaning of the behavior within the context of their social settings or social group involvement.

Population Served

Healthy for Life served boys (48 percent) and girls (52 percent) in the sixth, seventh, and eighth grades. Most students were aged 14 (68 percent) or 15 (29 percent). Almost all were White (96 percent) and most lived with two parents (72 percent). About 30 percent of parents had a college degree, and 86 percent of fathers and 58 percent of mothers worked full-time.

Setting

Healthy for Life was held in a classroom setting in Wisconsin middle schools.

Goals

The primary goal of *Healthy for Life* was to provide teens with social skills that would help them resist peer pressure to engage in risky health behaviors.

Main Messages

The program stressed abstinence and promoted contraceptive use for teens who were sexually active.

Operation/Logistics

Length of program: A total of 45 lessons were included in the program. Sixteen of them primarily addressed sex-related issues.

Components of program: The program included sex education classes and sessions on peers, family, and community. The sex education classes included lessons on refusal skills, communicating with parents about sex and values, body image, birth control, and risks associated with early sexual activity. For the peer section, students selected three leaders in each class, who then received training and assisted in teaching the curriculum. The family component encouraged parent-child discussions about sex and other risky health behaviors, and assisted families in clarifying their values about these issues. In each community, an organization was selected to provide at least one health event during the course of the program, and Healthy for Life community organizers assisted with this event.

Staffing requirements: A trained Healthy for Life teacher team taught the curriculum with a teacher from the participating school.

EVALUATION

Type

Schools elected to participate in either the intensive program or the age-appropriate program. They

¹ The profile of Healthy For Life is brief because the evaluation found that the program did not affect sexual behavior among teens.

were then randomly assigned to one of these programs or to a control group. Seven schools offered the age appropriate program, six offered the intensive program, and eight were in the control group. Students completed annual surveys between the sixth and tenth grades. The sixth grade sample consisted of 2,483 students. At the ninth grade follow-up, 1,981 students completed a questionnaire (80 percent response rate). The tenth grade follow-up had a 68 percent response rate.

Findings

At the tenth grade follow-up, students in the age appropriate program (36 percent of all participating students) and intensive program (33 percent) were *more* likely to have had sexual intercourse. Students in the control group (28 percent) had the lowest rate of sex. There was no significant difference between the intensive program and the control group or the intensive program and the age appropriate program. There were no differences between groups regarding condom use.

Ninth grade data indicated that students in the program groups were about 1½ times more likely to have ever engaged in sexual intercourse than students in the control group. No differences were found when examining sexual intercourse in the last month. Tenth grade data showed no significant differences between program participants and control group members on ever having had sexual intercourse or sexual intercourse in the past month.

Why no effects?

Evaluators offered several reasons to help explain the program's lack of success (Piper, Moberg, & King, 2000):

1. The program was too short and the population

- too small to demonstrate significant results.
- The community events did not focus on sexrelated issues and parents resisted discussing sex with their children, so these components were not effective.
- Students in the control schools were as likely to receive as much information about condoms as program participants, so the difference between the program and control groups was blurred.
- 4. *Healthy for Life* targeted all students rather than higher risk student populations that may have benefited more from it.

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RESOURCES

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HIV/AIDS and Other STD Education Programs

Focus on Kids¹ (Overview)

Focus on Kids was a community-based program designed to reduce HIV risk among African Americans aged 9–15. Participants met once-aweek for eight weeks. At each session, small groups of youth heard lectures, viewed videos, and/or participated in role playing and discussions. Primary topics included abstinence and contraception use. The goal was to encourage participants to adopt behaviors that would reduce their risk of contracting HIV. The program was evaluated in 1993 in nine recreation centers located in three Baltimore public housing developments.

An experimental evaluation of *Focus on Kids* revealed that, six months after completing the program, participants had greater intentions to use condoms and higher self-reported condom use than the comparison group. Participants did not demonstrate a greater knowledge of HIV prevention than control group members six months after completing the program. One year after the program ended, differences between the program and control groups disappeared. This suggests that *Focus on Kids* had a short-term impact.

To date, *Focus on Kids* has been evaluated only in an urban setting and only with African American youth. Currently, the program is being replicated in rural West Virginia and in the Bahamas, and these evaluation findings will be available in the future.

A kit that includes the *Focus on Kids* curriculum, evaluation materials, questionnaires, and a video is available for \$265 from the Program Archive on Sexuality, Health, and Adolescence (PASHA, see page 40). Group training is available from ETR Associates at an average cost of \$5,600 for development, \$2,600 for travel expenses, and \$105 per person for program materials for 20–50 teens.

INSIGHTS AFTER THE FACT

Key challenges

■ It is important to explain to members of the community why HIV prevention should be a priority. If adults, parents, and other leaders understand this point, they are more likely to accept *Focus on Kids*.

Lessons Learned

- The most important way to engage kids in the program is to make it enjoyable. It is less important where it is housed.
- Educating parents about the program content increases their support and involvement. In Baltimore, program staff developed a parent education session that summarized the sex education/HIV prevention information their children were receiving. This prepared the parents to answer any questions their children had about session topics.

SOURCE: DR. BONITA STANTON, CHAIR, DEPARTMENT OF PEDIATRICS, WAYNE STATE UNIVERSITY

More recent evaluations of specific components of *Focus on Kids* (which did not include a control group) have been called into question because of interviewer fabrications (Federal Register, 2003). However, these interviewers did not participate in studies cited in *A Good Time*, nor have any of the data collected by the interviewers in question been included in any published analyses of *Focus on Kids* (UPI, 2003; Stanton personal communication, 2003; Stanton et al., 2003). In fact, the study director of *Focus on Kids*, Dr. Bonita Stanton, initiated the review of these interviewers (UPI, 2003).

Focus on Kids

PROGRAM DESCRIPTION

Focus on Kids was a community-based HIV prevention program evaluated in 1995.

Type of Intervention

Youth were recruited at community recreation centers and each was asked to select between three and ten friends of the same gender to form a "friendship group." Each group was run by two adult facilitators and met weekly. Meeting activities ranged from lectures by the facilitators to role playing and group discussions. The boys and girls also participated in short "field assignments," such as calling an HIV hotline to ask questions.

Focus on Kids was based on the protection motivation theory. This theory posits that at-risk adolescents can prevent HIV transmission if they understand the risks and consequences of their behaviors and have considered strategies for avoiding risky sexual behaviors.

Population Served

Focus on Kids served low-income African American youth aged 9–15. Some were in school, while others had dropped out. More than half of the participants were male (56 percent) and more than one-third (36 percent) had already had sexual intercourse before the program started.

Setting

Focus on Kids was held in nine recreation centers in urban, low-income communities of Baltimore, Maryland. Program planners selected recreation centers rather than schools because they believed the highest risk youth were less likely to be in schools. The social nature of recreation centers also made it easier for youth to recruit their peers for the program.

Goals

Focus on Kids aimed to prevent at-risk youth from acquiring HIV by increasing their under-

standing of HIV transmission and teaching them about prevention strategies, such as abstinence and condom use.

Main Messages

The program was considered an "abstinence plus" program. Participants were taught that abstinence and avoiding drug use were the only certain ways to prevent HIV infection. They also learned about the effectiveness of condoms and other contraceptives in preventing pregnancy, HIV, and other sexually transmitted diseases.

Operation/Logistics

Length of program: The intervention consisted of eight 90-minute sessions. Facilitators could substitute a one-day retreat for one of the sessions.

Size of program: At each program site, between three and ten same-gender youth comprised a "friendship group." Each group worked with two adult co-facilitators.

Components of intervention: Focus on Kids consisted of two primary components. First, the facilitators showed a video about sexual health; told the participants about useful informational resources on HIV; discussed the consequences of risky sexual behaviors; and worked on building communication skills regarding HIV prevention.

Second, adolescents participated in role playing and small-group discussions about topics such as saying "no" to sex and the risks of sex. Using the "SODA" decision-making model (Stop and state the problem; Options — consider the options; Decide and choose the best solution; Action — act on your decision), teens were taught to think through risky situations and consider potential consequences of their behavior.

Staffing requirements: Two adult co-facilitators
— who were of the same gender as the group
members — led each "friendship group."

CURRICULUM

The curriculum includes age-specific lessons with separate information for teens aged 9–12 and 12–15.

- **Session 1** "Trust Building and Group Cohesion" includes games that help establish ground rules for how the group will operate. It also provides materials the group leaders can use to teach lessons on decision-making.
- Session 2 "Risks and Values" focuses on helping teens define and rank their own values. Using a brainstorming activity, participants create a list of safe-sex activities (such as massaging and dancing) and safer-sex guidelines (such as using a condom when having intercourse). In addition, during this session participants learn that abstinence and avoiding drug use are the best ways to prevent the transmission of HIV.
- **Session 3** "Educate Yourself: Obtaining Information" explains how adolescents can gather information that will help them make informed decisions about HIV prevention.
- Session 4 "Educate Yourself: Examining Consequences" includes information on proper condom use and a discussion about the possible outcomes for teens who are sexually active.
- **Session 5** "Skills Building: Communication" focuses on communication styles, interacting with partners, and decision-making skills.
- **Session 6** "Information About Sexual Health" teaches about HIV transmission and contraception. In this session, participants discuss various ways to show care for someone without having sexual intercourse. In addition, various forms of contraception are discussed during this session.
- Session 7 "Attitudes and Skills for Sexual Health" addresses ways to set personal goals. It also includes role playing exercises, which teach youth how to say "no" to sex or insist on condom use, for example.

allows program participants to select a community project designed to provide them with an opportunity to share knowledge and experience gained from the program. Such projects could include creating posters with HIV prevention information for display in schools and recreation centers; writing articles for a school or community newspaper; or creating skits for presentation at school assemblies.

EVALUATION

Type

Focus on Kids used an experimental, random-design evaluation. In total, 383 adolescents were matched according to common characteristics. Two hundred and six were randomly assigned to the program group, and 177 were assigned to a control group. All youth were African American and the average age was 11.3 years old. They were interviewed six and 12 months after the program ended.

Components

Instruments and frequency: Evaluations were based on results from three identical questionnaires given to all 383 adolescents. They filled out the questionnaires before the program started and then six and 12 months after completing it.

Outcomes measured: Knowledge and attitudes about HIV prevention were assessed. These included whether youth knew condoms were protective against HIV transmission; measures of teens' intentions to use condoms in the future; and actual condom usage by sexually active youth. No abstinence measures were included in this evaluation.

Findings

Teens who participated in *Focus on Kids* had more positive condom-use outcomes six months after finishing the program than did the control group teens. Six months after completing the program, participants also perceived greater risks of

not using condoms and were more likely to report condom use intention than were adolescents in the control group (3.4 versus 2.9 on a one to five scale). Additionally, adolescents in *Focus on Kids* were more likely to report using condoms the last time they had sex than were members of the comparison group (85 percent versus 61 percent). However, participants and control group members did not differ on their knowledge of HIV prevention six months after the program ended, and all significant differences between the two groups disappeared by the 12-month evaluation. The program evaluators suggested that booster programs to help sustain the intervention impacts should be explored and evaluated (Stanton et al., 1996).

Focus on Kids is currently being evaluated in rural West Virginia and in the Bahamas.

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Website: http://www.socio.com/pasha.htm

Cost: \$265

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Making Proud Choices! A Safer Sex Approach to HIV/STD and Teen Pregnancy Prevention (Overview)

Making Proud Choices! was a community-based program for sixth and seventh grade African American adolescents. Like Making a Difference!, Making Proud Choices stressed that abstinence is the best way to prevent HIV, other sexually transmitted diseases (STDs) and pregnancy, but Making Proud Choices! also taught that condoms can be effective too. The program was held in two four-hour sessions in three Philadelphia middle schools. (The program also could be taught in eight one hour sessions.)

At the 12 month follow-up, sexually experienced teens in *Making Proud Choices!* reported a lower frequency of unprotected sex than those in the control group. There were no differences found between program participants and the control group on measures of sexual behavior among youth who were virgins at the start of the program. An experimental, random-assignment evaluation of *Making Proud Choices!* is currently underway with Latino and African American teens in Philadelphia.

Teens received \$100 (\$40 for completing the program and \$60 for participating in the evaluation). The curriculum can be purchased for \$100, and videos are additional. Training costs are not available.

INSIGHTS AFTER THE FACT

Key challenges

- In order to sustain the effects of *Making* Proud Choices! over time, it was supplemented with another program entitled, Promoting Health Among Teens (PHAT). PHAT adds a maintenance component to the safer-sex curriculum, includes a three-module "booster" session (either six weeks or three months after the program ends), and distributes six issues of a newsletter that reinforces lessons learned in the program. The maintenance component includes six one-on-one sessions with the teen's original facilitator to reinforce the safer-sex message and to assess whether the teen is practicing safer sexual behaviors. PHAT is following teens for 24 months to see whether effects are sustained over time.
- It is important to ensure that facilitators adhere to the curriculum as it is written and not try to modify it in any way.

Lessons Learned

- This program works best in schools and communities that recognize teens are at-risk for HIV, other STDs, and unintended pregnancies.
- The evaluation results suggest that intensive, culturally-appropriate approaches that are based on theory can reduce some risky sexual behaviors among inner-city African American adolescents.

Source: Dr. John Jemmott, University of Pennsylvania, Director, Center for Health Behavior & Community Research. Note: Dr. Jemmott commented on *Making a Difference!* and *Making Proud Choices!*

Making Proud Choices! A Safer-Sex Approach to HIV/STD and Teen Pregnancy Prevention

PROGRAM DESCRIPTION

Making Proud Choices! was designed to increase knowledge about HIV, other STDs, and teen pregnancy prevention among African American middle schoolers. It also taught them that condom use is one important prevention strategy.

Type of Intervention

Small groups comprised of six to eight teens met for two four-hour sessions. They watched videos and participated in discussions, games, role playing, and other exercises. Trained facilitators led each small group. Adult-led groups had one facilitator and peer-led groups had two. Youth received a stipend to participate in the program and to complete surveys at baseline and at regular intervals after the program ended.

Population Served

Participants were low-income, African Americans adolescents in sixth and seventh grades. The average age was 11.8 years, and just over half (53 percent) were girls.

Setting

Making Proud Choices! was held in three Philadelphia, PA, middle schools in low-income communities.

Goals

The program aimed to reduce the risk of HIV/STDs and pregnancy among youth. The program stressed abstinence and condom use. After completing the program, youth were expected to have greater knowledge about HIV/STD and pregnancy prevention, better negotiating skills, and reduced risk-taking behaviors.

Main Messages

Making Proud Choices! presented abstinence as the best way to avoid HIV, other STDs, and pregnancy. The program also discussed condom use as an important option for reducing risks for sexually active teens. Other key messages conveyed were that participants should be proud of themselves and their community and that they should consider how taking risks today could prevent them from attaining their future goals.

Operation/Logistics

Length of program: Making Proud Choices! was held over two days in two four-hour sessions. (The program also could be presented in eight one-hour sessions.)

Size of program: Teens were randomly assigned to the program (218 participants) or the control group (214 participants).

Components of intervention: The intervention had four components:

- 1. Helping teens define their goals and consider how having sex could prevent them from achieving those goals.
- Increasing knowledge about HIV/STDs and pregnancy;
- Discussing attitudes towards abstinence, HIV/STDs, and pregnancy; and
- 4. Teaching skills for negotiating condom use.

Staffing requirements: Each group had one adult facilitator or two peer facilitators, all of whom were African American. All adult facilitators had prior experience working with youth, and they received two and a half days of training. Peer facilitators were students from Philadelphia high schools who received three days of training on small-group facilitation and leadership and four days of training on how the program operated. An observer monitored the small groups to ensure program consistency.

CURRICULUM

Making Proud Choices! includes eight lessons:

- Lesson 1 "Getting to Know You and Making Your Dreams Come True" provides a program overview. Participants develop a set of "group rules" to govern the sessions. They discuss their goals and consider barriers that may stand in the way of achieving them. This session includes discussions of unintended pregnancy, STDs, and HIV.
- **Lesson 2** "The Consequences of Sex: HIV Infection" focuses on the consequences of risky behavior. Teens watch a video, "The Subject is HIV," and discuss HIV prevention strategies.
- Lesson 3 "Attitudes and Beliefs about HIV/AIDS and Condom Use" addresses how HIV is transmitted and how to prevent transmission. Teens watch a video, "AIDS Not Us," and perform a role playing activity, "Tell it to Tanisha AIDS Information Hotline," where they offer solutions to "callers" who have questions about HIV.
- Lesson 4 "Strategies for Preventing HIV Infection: Stop, Think & Act" encourages teens to make safe choices regarding sex so they can reduce their exposure to HIV. Facilitators show two video clips, "Nicole's Choice" and "Jesse," to prompt discussion about the importance of thinking about situations before taking action. In another activity, "AIDS Basketball," participants score points when they correctly answer questions about HIV/AIDS.
- Lesson 5 "The Consequences of Sex: STDs" explains how STDs affect peoples' lives. Teens watch a video, "The Truth about Sex," and play "The Transmission Game," which emphasizes how easily someone can contract an STD. Participants discuss their attitudes about risky sexual behavior and contraceptive use.
- **Lesson 6** "The Consequences of Sex: Pregnancy" clarifies "myths" and "facts" about

- pregnancy. The teens also discuss available methods of birth control and attitudes toward contraception use.
- Lesson 7 "Developing Condom Use Skills and Negotiation Skills" teaches participants how to use a condom and to negotiate condom use. Role playing helps teens learn how to refuse unprotected sex.
- Lesson 8 "Enhancing Condom Use Negotiation Skills" uses role playing to help teens learn how to resist risky behaviors. A video, "Be Proud! Be Responsible! Negotiation Video Clip," illustrates negotiation skills.

EVALUATION

Type

Making Proud Choices! used a random assignment experimental design. The control group received a two-day, four-hour program on general health promotion. Approximately 93 percent of the teens participated in the 12-month evaluation, which tested whether students in Making Proud Choices! reported greater condom use than the control group.

Components

Instruments and frequency: The youth completed a questionnaire before the program, immediately after completing the program, and at three-, six-, and 12-month intervals after it ended.

Outcomes measured: The primary outcomes measured were sexual behaviors and condom use (in the past three months), including:

- sexual intercourse (yes vs. no)
- frequency of sex (number of days of intercourse)
- consistency of condom use (always using a condom during intercourse)
- frequency of condom use (rated on a scale of one [never] to five [always]), unprotected sexual intercourse (yes vs. no), and frequency of unprotected intercourse (number of days of intercourse when a condom was not used).

Findings

Twelve months after completing the program, participants reported a higher frequency of condom use (4.2 vs. 3.2 on a scale of one [never] to five [always]) than control group members. Among youth who were sexually active before the program, those in *Making Proud Choices!* reported a lower frequency of intercourse (1.3 days vs. 3.8 days), a lower likelihood of unprotected intercourse (9.7 percent vs. 31.6 percent), and a lower frequency of unprotected intercourse (.04 days vs. 1.9 days) than teens in the control group. Youth who were virgins at the start of the program did not differ on any of the outcomes measured compared to virgins in the control group.

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Youth AIDS Prevention Project (YAPP) (Overview)

The Youth AIDS Prevention Project (YAPP), a school-based HIV/AIDS education program located in 15 Chicago-area school districts, was designed for seventh graders. Its primary goal was to prevent STDs, including HIV and AIDS, and substance abuse. YAPP consisted of ten 50-minute classes held over a two week period during seventh grade and a five-session "booster" during the eighth grade year.

An experimental evaluation conducted immediately after the two-year program ended found that program participants were more likely to report ever using condoms with foam and were marginally less likely to have had recent sexual activity than were control group members. Participants and control group members did not differ in their use of condoms without foam or on the number of sexual partners in the preceding 12 months. One year after *YAPP* ended, the groups did not differ with regard to sexual activity or condom use.

YAPP was tested in urban and suburban settings, and many of the program materials initially developed for seventh and eighth graders have been used in programs serving older and younger children. Some new materials also have been created for fourth, fifth, and sixth graders and for high school students.

A kit that includes the curriculum, videos, role playing cards, a student and parent handbook, and handouts is available for \$590 from the Program Archive on Sexuality, Health, and Adolescence (PASHA). Condoms, spermicidal foam, and vagi-

nal contraceptive film must be purchased separately. Instructor training takes one to two days and costs \$500–\$600 for duplicating program lessons and materials.

INSIGHTS AFTER THE FACT

Key challenges

- *YAPP* was developed in the late 1980s before the public understood HIV as a disease that could affect youth. This made it challenging to convince school districts to participate.
- One important strategy for securing and maintaining schools' participation was the development of contracts that clearly laid out the respective roles of those conducting the program and the school district.

Lessons Learned

- Engaging parents through homework assignments, rather than having them directly participate in the program, seemed a more effective and comfortable strategy for the kids and the adults in their lives.
- In hindsight, program representatives believe it would have been more effective to direct more resources towards the kids in the program rather than towards efforts to engage parents.
- When serving younger adolescents, it is important to make sure that an ageappropriate curriculum is used.

SOURCE: SUSAN LEVY, Ph.D., PREVENTION RESEARCH CENTER

Youth AIDS Prevention Project (YAPP)

PROGRAM

The Youth AIDS Prevention Project (YAPP) was an STD, HIV/AIDS, and substance abuse prevention program carried out during the 1991–1992 school year in 15 school districts in the Chicago metropolitan area. The school districts were selected based on the prevalence of HIV infection, rates of teen pregnancy and STDs, school dropout rates, and reading scores from state exams. Also taken into account were the proportion of the population living in poverty and the proportion of minorities in the school districts.

Type of Intervention

The program was designed using social cognitive theory and the social influence model of behavior change. Social cognitive theory posits that knowledge alone is not enough to create behavioral change. Also necessary are four other components:

1) information; 2) social skills for translating knowledge into behavioral change; 3) opportunities to develop skills and self-efficacy; and 4) efforts to strengthen social supports. The social influence model approach uses peer group discussions and other opportunities for students to build social skills.

Population Served

Seventh grade boys (48 percent) and girls (52 percent) participated in the *YAPP* program. More than half were African American (56 percent), while 23 percent were White, 17 percent were Hispanic, and five percent comprised other racial/ethnic groups.

Setting

YAPP occurred in Chicago area schools as part of the school day. Participants also had assignments to complete at home, and one intervention group had to complete several assignments with a parent.

Goals

YAPP's primary goals were to prevent STDs, including HIV/AIDS, and substance abuse.

Secondary goals included increasing AIDS knowledge, improving condom use, enhancing negotiation skills around sex, and promoting abstinence.

Main Messages

Students received information about transmission and prevention of HIV/AIDS and other STDs. Abstinence was presented as the only certain prevention strategy, but sexually active youth were urged to use condoms consistently.

Operation/Logistics

Length of program: Youth received 10 classroom-based sessions in the seventh grade and five follow-up sessions in the eighth grade. Sessions were held daily and lasted 40 to 50 minutes. The program spanned two weeks during the seventh grade and one week in the eighth grade.

Size of program: All together, 1,459 students in 11 schools participated in *YAPP*, and 933 students in six schools served as the control group.

Components of intervention: The intervention had two components: 1) classroom instruction, which was given to all program participants, and 2) parental involvement, which included homework assignments to be completed with a parent as well as parent meetings.

Staffing requirements: Although YAPP was designed to be led by a master's level health professional, teachers can serve in this capacity with appropriate training. Each session required one instructor.

CURRICULUM

The seventh grade *YAPP* curriculum includes classroom discussion, a workbook, videos, role playing, an anonymous "question box," and homework assignments.

■ **Session 1: Decision-Making** introduces students to the *YAPP* program and presents the SAFER method of decision-making: studying a

- situation, determining alternative choices, finding the best alternative by considering the advantages and disadvantages of each choice, executing a plan, and reviewing the outcome. Students are given an opportunity to practice the SAFER method.
- Session 2: Resistance/Negotiation Skills focuses on helping youth identify large and small decisions. Students also are taught "the Six Ss" of negotiating: 1) Stop, look, and listen; 2) Say no; 3) State your response repeatedly, and in different ways; 4) Suggest other things to do; 5) Say good-bye; and 6) Stay away. Role playing is used.
- **Session 3: A is for AIDS** provides information on HIV/AIDS transmission and prevention, the stages of HIV, and the treatment of AIDS. Students view the video "A is for AIDS".
- Session 4: Prevention (Abstinence & Safer Sex) teaches abstinence as the only certain way to prevent STDs, including HIV/AIDS.

 Contraceptive methods are taught, and students are shown how to properly use condoms and spermicidal foam/film.
- Session 5: Whose decision is it? allows students to discuss the influence of the media on decision-making.
- Session 6: Teen AIDS uses the video "Teen AIDS in Focus," which presents information on how AIDS has affected teens. Youth discuss the video and participate in an "HIV Express" activity, which clarifies how HIV is spread.
- Session 7: Prevention (Be Safe Don't Do Drugs) describes prescription, over-the-counter, and illegal drugs as well as substance abuse and misuse. Students discuss the story "Drugs: A Story About Kirk," and brainstorm about why teenagers use drugs.
- Session 8: STDs: Stop that Disease presents information about STDs. The goal is to enable students to identify at least four STDs and STD symptoms, and to know how STDs are transmitted.

- Session 9: Drugs and STDs uses a story, "STDs: A Story About Steve and Laura," to discuss taking responsibility for STD prevention. "Give Me Your Best Jive/Line!" is an activity through which students learn negotiation skills regarding safer sex practices.
- Session 10: Program Review provides an opportunity for students to review the content of previous classes. In addition, the session includes an activity, "Wipe Out AIDS," to assist students in integrating all they have been taught.

The seventh grade parental involvement component seeks to increase parents' knowledge about AIDS so they can reinforce what the teens have learned in the classroom. The parents complete five homework assignments with their teens and participate in one parent workshop, which provides an overview of the *YAPP* program and information on trends in sexual behavior and drug use among teens.

The eighth grade *YAPP* program consists of five sessions:

- Session 1: Making Decisions allows students to review SAFER decision-making skills (seventh grade session one) and to review the "Six Ss" of negotiating (seventh grade session two). Students do role playing exercises and prepare autobiographies that project what their lives will be like five years in the future.
- Session 2: Sexuality and STDs (HIV/AIDS) reviews the stages of HIV and AIDS (seventh grade session three). Students also discuss HIV testing and review issues related to STDs.
- Session 3: Relationships, Abstinence, & Safer Sex includes discussion about relationships and how to manage them. Facilitators explain proper use of condoms and spermicide foam/film. Students complete a worksheet, "STDs: Check Your Knowledge," as homework.
- **Session 4: Preventing Risky Behaviors** has students role play to practice the SAFER method

- of decision-making and the "Six Ss." Students also discuss why teens use drugs and possible consequences.
- Session 5: Ready for the Future includes a discussion of the students' autobiographies, including what they need to do to achieve their goals. They also focus on the transition to high school using a homework assignment, "Next Step: High School."

EVALUATION

Type

Fifteen school districts were randomly assigned (five districts in each group) to either the classroom sessions/parent involvement intervention (five schools); the classroom sessions/no parent involvement intervention (six schools); or the control group (six schools). The seventh grade baseline survey was administered to 2,392 students (1,459 program participants and 933 control group students).

Components

Instruments and Frequency: Surveys were administered three times: at baseline in the seventh grade, in the eighth grade following the booster program, and in the ninth grade. The retention rate was about 67 percent at the eighth grade follow-up and 56 percent at the ninth grade follow-up.

Outcomes measured:

- age at first sex;
- frequency of sexual intercourse in the past 30 days;
- number of sexual partners in the past 12 months;
- condom use or condom use with foam at last sexual intercourse;
- ever used condoms, condoms with foam;
- for sexually experienced teens, intentions to use condoms or condoms with foam at the next sexual intercourse experience; and

 for students not sexually experienced, intentions to use condoms or condoms with foam at the first sexual intercourse experience.

Findings

At baseline, the control group had a higher proportion of students who were African American than did the program group (64 percent vs. 56 percent) and a lower proportion of students who were Hispanic (six percent vs. 17 percent). Other baseline characteristics did not differ. Approximately one-third of all students reported having had sexual intercourse before the program started.

For the eighth grade follow-up, students in both treatment groups (parent involvement and no parent involvement) were combined for analyses because there were no differences on outcomes. Program participants (24 percent) were more likely to report ever using condoms with foam than were control group students (15 percent), but there were no differences on ever using only condoms. Program participants were marginally more likely to report not having sex in the past 30 days than were control group students (74 percent vs. 65 percent). No differences were found following the intervention (eighth grade follow-up) between the treatment and control groups on the number of sexual partners in the past 12 months or on condom use measures. Among those sexually active in the past 30 days, students in the program and the control group did not differ on use of condoms alone, use of condoms with foam, or intentions to use just condoms. However, program participants were more likely to report intentions to use condoms with foam when engaging in sexual intercourse than were control group students (85 percent vs. 63 percent).

When combining both program groups, the ninth grade follow-up found they were more likely to report planning on using condoms with foam the first (or next) time they had sexual intercourse than the control group. Program participants and control group students did not differ on age at first

sexual intercourse, purchase of condoms, use of condoms at first or most recent intercourse, or intentions to use condoms at first (or next) sexual intercourse.

To bolster the program's effects, the evaluator suggested that *YAPP* be introduced to younger teens and be extended over a longer period of time.

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AIDS Risk Reduction Education and Skills Training (ARREST)¹

** Experimentally Evaluated Program That Did Not Affect Teen Sexual Behavior **

PROGRAM DESCRIPTION

The AIDS Risk Reduction and Skills Training Program (ARREST) was a community-based afterschool HIV/AIDS risk reduction program that served adolescents aged 12 to 16.

Type of Intervention

The AIDS Risk Reduction and Skills Training Program (ARREST) was a community-based program for African American and Latino adolescents, aged 12-16, who were considered to be at high risk for HIV infection. The ARREST program utilized a five-session format to educate adolescents about HIV/AIDS transmission and prevention. The first and last sessions were used for assessments. The other three sessions incorporated role playing, group discussions, homework assignments, and skill-building exercises. Each session began with a discussion to review materials from the previous session, addressed participants' questions, and focused on a specific topic. At the end of each session, a take-home exercise was given to participants to encourage them to practice skills addressed during that session. The program provided explicit instruction on condom use.

Population served

The only requirements for participation were the ability to speak English and written parental consent. Program participants were Latino (59 percent) and African American (41 percent) teens. Forty-five percent were boys and 55 percent were girls aged 12–16 years.

Setting

The ARREST program was facilitated once a week for five weeks in community-based settings

serving high-risk youth in New York City. The program was held after school hours.

Goals

ARREST focused on providing information on HIV prevention and improving teens' ability to make informed decisions about participation in sexual activity. The program enhanced participant skills in assertiveness and communication in order to reduce sexual behavior risks.

Main Messages

The primary message conveyed through the *ARREST* program was that knowledge alone is not enough to reduce participation in risky behavior. The program recognized that it is important to educate teens about HIV infection and then provide activities that foster the development of risk reduction skills. *ARREST* provided information on the benefits of abstinence as well as information on condom use.

Operation/Logistics

Length of program: The ARREST intervention consisted of five sessions that were held once a week, lasting 90 minutes per session. Sessions One and Five were used for assessment.

Components of intervention: The ARREST intervention included a five-session curriculum focused on HIV/AIDS prevention and risk reduction. The curriculum consisted of an introductory session, three modules, and an assessment session. The first module provided accurate information about what HIV/AIDS is, how it is transmitted, how it is treated, and ways to prevent exposure. The second module addressed risky behaviors and prevention. Participants learned about the effectiveness of condoms as well as how and where to buy them. They also were given the opportunity to learn proper use of condoms. The final module was the skills training session, which focused on communication, assertiveness, and negotiation skills.

¹ This profile of the AIDS Risk Reduction Education and Skills Training (ARREST) is brief because the evaluation found that the program did not affect sexual behavior among teens.

Participants in this program received a \$5 stipend at the end of each session. If participants attended all of the sessions, they received an additional \$5 at the conclusion of the program.

Staffing requirements: The ARREST program should be facilitated by an adult who is skilled and knowledgeable in the field of AIDS education. It is recommended that one facilitator lead a group of 10 to 12 youth. Facilitators should have experience in leading group discussions and role plays with adolescents, as well as the ability to model the behaviors that are being taught.

EVALUATION

Type

The ARREST Program incorporated an experimental design evaluation. High-risk youth were recruited from community-based agencies to participate in the ARREST after-school program. After youth were recruited for the program, they completed an initial questionnaire and role playing assessment (87 participants). Adolescents were then randomly assigned to participate in the ARREST program (41 participants) or were put on the waiting list for the program to act as the control group (47 participants). All adolescents were interviewed again with a questionnaire and a role playing assessment four weeks after the initial questionnaires were completed.

Questionnaires measured several outcomes related to the risk of contracting HIV/AIDS, including "knowledge of HIV transmission and prevention" (31 questions), "negative attitudes and beliefs about the cause of AIDS" (17 questions), "perception of risk" (two questions), "self-efficacy" (four questions), and "involvement in HIV risk-related sexual and drug-use behaviors" (Kipke, Boyer, & Hein, 1993). In addition, the survey measured age at first sexual intercourse, number of sexual partners (in the past month), and condom use (in the past

month). Role play assessments measured decision-making, assertiveness, and communication skills of teens when placed in a simulated high-risk situation.

Findings

Although there were no significant differences in outcomes at the pre-test time period, at post-test, adolescents who participated in ARREST had greater increases in knowledge of HIV/AIDS (26.7 versus 22.0 on a scale of 1 to 31) compared to members of the control group. Program participants also had greater increases in knowledge about perceived risks of contracting HIV and less negative attitudes about AIDS or people who have AIDS than members of the control group. ARREST participants also were more likely to have better overall assertiveness and communication skills. ARREST participants had greater skills in providing a reason for refusal to participate in high-risk behavior and providing a low-risk alternative than adolescents in the control group. Nevertheless, participation in the program did not reduce number of sexual encounters, number of sexual partners, use of condoms, or involvement in unprotected sexual intercourse, nor did participation increase perceived self-efficacy or refusal skills.

Why no impacts?

Evaluators of the ARREST program suggested that the short length of this intervention (three training sessions) may have contributed to the program's lack of effectiveness on sexual and contraceptive use behaviors (Kipke et al., 1993). They also suggested that the findings may reflect small sample size and the small number of sexually experienced teens who were followed for a short period of time. However, the evaluators noted that the program had a positive impact on knowledge, attitudes, and perceived risk of contracting HIV/AIDS, which are considered to be important precursors to behavioral change.

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RESOURCES

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Service Learning Programs

Reach for Health Community Youth Service (RFH-CYS) (Overview)

Reach for Health Community Youth Service (RFH-CYS) was a school-based service learning program located in Brooklyn, NY that combined community field placements with classroom health instruction. This program, conducted from 1994–1996, was designed to help at-risk middle school students build knowledge, attitudes, and skills to guide them in making decisions about their own health and well-being. RFH-CYS was conducted over 30 school weeks.

Through field placements in health and social service settings, students gained experience and confidence. Weekly *RFH-CYS* classroom lessons reinforced teens' community service experiences and taught them how to reduce the risks related to sexual intercourse and other behaviors.

An experimental evaluation of *RFH-CYS* found that at a two-year follow-up, program participants were significantly less likely than the control group to report sexual initiation through the tenth grade.

The *RFH-CYS* program materials will be forth-coming through the Program Archive on Sexuality, Health, and Adolescence (PASHA). Other expenses include a full- or part-time program coordinator; additional student materials, such as certificates, badges, and t-shirts that students receive as rewards; local travel (particularly travel to and from field placement sites); compensation for teachers; photocopying and postage; and hiring and supervising an evaluator.

INSIGHTS AFTER THE FACT

Key challenges

- Some in the school community resisted service learning because these programs require students to be off-campus. Involving students, parents, teachers, and administrators at the outset in the planning process can help alleviate such resistance. Once on board, these community members can help with fundraising, public relations, and planning celebrations at the end of the service component.
- Organizational and logistical challenges include arranging travel to and from fieldsites, recruiting new field sites that can provide community experiences, and monitoring field site activities.

Lessons Learned

- It is important to have support from administrators at the school and in community agencies where service happens. It is also important to have well-trained program staff, including health education teachers, program coordinators, and agency staff.
- Designating one person to manage program activities between school and community sites is very helpful.
- Select field placements carefully so they match the needs and interests of students, provide meaningful work opportunities, and are compatible with the goals.
- Ample time should be built into classroom instruction for student reflection and debriefing on community service experiences.

Source: Kim Dash, Educational Development Center

Reach for Health Community Youth Service (RFH-CYS)

PROGRAM DESCRIPTION

Reach for Health Community Youth Service Learning (*RFH-CYS*), conducted from 1994–1996 in two large Brooklyn, NY middle schools, was a school-based service learning program. It aimed to encourage at-risk adolescents to avoid risky sexual behaviors.

Type of Intervention

RFH-CYS was a school-sponsored program that combined service learning and skills-based health instruction. The program was designed in collaboration with a large public middle school in Brooklyn and built upon a pilot program conducted by the school community in collaboration with the School of Nursing at Medgar Evers College, City University of New York. School staff and a community advisory board worked with program developers from the Education Development Center to create a protocol for the service learning component and to ensure that classroom health lessons were culturally and developmentally appropriate. Curriculum lessons were active, geared toward diverse learning styles, and designed to be easily integrated into school health programs.

The program linked the school with the community and provided students with meaningful opportunities for community engagement. In doing so, it aimed to instill youth with a citizenship ethic, a concept drawn from John Dewey's theory of associated learning, which emphasizes the relationship between personal achievement and intellectual growth. The health instruction component reinforced service experiences and was grounded in social cognitive theory. This theory emphasizes the importance of developing social competence and social skills that are critical to risk reduction. The program also was based on research exploring the culture- and gender-based reasons why young adolescents engage in unhealthy behaviors and how they can be supported to make healthy choices.

Population Served

RFH-CYS served seventh and eighth grade students at increased risk of early sex and related risky behaviors. At the original urban evaluation site, almost all students were African American and Latino.

Setting

RFH-CYS was conducted during the school day in middle school health classes and in surrounding community healthcare and social service settings, such as day care centers, nursing homes, health clinics, or senior centers. Sites were required to have adequate staffing to provide supervision to student volunteers and meaningful work experiences.

Goals

RFH-CYS sought to prevent risky sexual behaviors and other detrimental behaviors among at-risk youth.

Main Messages

The program emphasized that the teens' contributions were valuable to the community and that the community cared about their future. *RFH-CYS* also highlighted the following themes:

- **Protection:** We must take action, individually and as a society, to protect our health and wellbeing and to protect the health and well-being of others in our community.
- Responsibility: We each must act responsibly, respecting ourselves and others, and identifying the things we can change in ourselves and our surroundings.
- **Interdependence:** We are all connected; therefore, our actions, the actions of our peers, and the actions of the greater community matter to all of us.
- Affirmation of Positive Behaviors: Our efforts to promote health in ourselves and our community are supported by members of our community, and we can take pride in staying healthy.

Operation/Logistics

Length of program: Over 30 weeks of the school year, students attended field placements on a weekly basis, with each visit lasting two or three hours. Classroom lessons prepared students for field placements and provided opportunities for debriefing and reflection. The *RFH* curriculum also included 10 lessons on growth and development.

Size of program: A total of 35 classrooms at the program school received the program; 22 classrooms (222 students) received the core *RFH* curriculum (classroom component only). An additional 13 classrooms (255 students) received the *RFH* curriculum and the service learning components (CYS).

Components: RFH-CYS included two core elements: the RFH growth and development curriculum and the community youth service (CYS) (i.e., community field placements coupled with in-class preparation, debriefing, and reflection).

Staffing requirements: RFH-CYS required collaboration between middle schools and community service sites. School administrators selected a school-based coordinator to manage activities between school and community sites. The coordinator was responsible for:

- developing a protocol for student travel to and from field-sites;
- reviewing teacher performance and providing feedback;
- recruiting new field sites;
- conducting discussion groups with students; and
- visiting field sites to monitor activities.

Classroom teachers, preferably with health instruction training and experience, taught the classroom component of *RFH-CYS*. They were responsible for selecting and working with community placement sites and integrating service into the curriculum.

At the field placement sites, agency staff mentored students. Before field placements began, agency and school staff participated jointly in a program orientation that laid out goals of the *RFH-CYS* program and clarified the responsibilities of adults and youth.

CURRICULUM

Reach for Health (RFH)

The Reach for Health (RFH) curriculum contains 10 seventh grade and 10 eighth grade lessons on healthy development designed to supplement existing health curricula. It focuses on sexual behaviors that can result in HIV infection, other STDs, and pregnancy. The curriculum seeks to help students choose healthy options, communicate their needs effectively, and avoid risky behaviors. It also offers opportunities for students to learn and practice skills such as self-assessment, risk assessment, communication, decision-making, goal-setting, healthy self-management, and refusal skills.

Community Youth Service (CYS)

Community Youth Service, or service learning, is a method of instruction in which students learn and develop through active participation in service experiences that meet community needs. These experiences are integrated into the student's academic curriculum. At the beginning of each school term, students participate in an orientation that defines the goals of service learning, provides codes of conduct, and prepares them for specific responsibilities and situations (such as what they are likely to see in a nursing home and how to be respectful of elders). During this time, they:

- learn more about the organization to which they are assigned;
- set personal goals for what they want to achieve in the field;
- recognize the importance of their role in the site where they will be working;
- make predictions about what to expect on site;
 and

 consider and, as necessary, challenge their current attitudes about the population with whom they will be working.

When they complete the orientation lessons, students receive a certificate of completion and an identification badge to wear to their field placements.

Students participate in two field placements per year (one each semester). Over the year, students spend approximately three hours per week for 30 weeks (90 hours per year) in community youth service and in the classroom.

At field placements, students work under the direction of site staff who serve as mentors. Students serve in settings such as nursing homes, senior centers, full-service clinics, and child day care centers. Their responsibilities range from reading to the elderly and assisting during medical examinations to answering phones, scheduling appointments, filing, and helping in recreation and arts and crafts groups. In the classroom, teachers work with students to help them make observations, pose questions, and analyze their experiences.

EVALUATION

Type

Between 1994 and 1996, two large middle schools in Brooklyn, NY were recruited to participate in an evaluation of *RFH-CYS*. One school participated in the program and the other served as the control group school. A total of 68 classrooms participated. In the control school, 33 classrooms (584 students) received the standard New York City health education program, which included mandated lessons on drug use and AIDS. Within the program school, 22 classrooms (222 students) were randomly assigned to receive the core *RFH* curriculum (classroom component only) and 13 classrooms (255 students) received the *CYS* and the *RFH* curriculum (community field placements and classroom component combined).

In 1998, a second study evaluated the sustained effectiveness of *RFH-CYS* on reducing sexual risktaking. This study included students at the middle school that provided the *RFH-CYS* intervention or just the classroom curriculum. Researchers compared the self-reported sexual behavior of students who received the full *RFH-CYS* intervention with the self-reported sexual behavior of students who received the *RFH* curriculum only. They then assessed the dosage effects of the community youth service component by comparing three groupsthose who received two years of *CYS*, those who received one year of *CYS* (i.e., one year of *CYS* and one year of curriculum only), and those who received two years of curriculum only.

Components

Instruments and frequency: Self-administered health surveys were conducted at baseline in the fall of 1994 and again in the spring of 1995 (a sixmonth follow-up). Nearly 92 percent of the 1,157 students who completed the baseline survey completed the spring survey. A two-year follow-up was completed at the end of tenth grade.

Outcomes measured: Youth were asked questions about sexual behavior at baseline and follow-up, including life-time experience with intercourse (yes/no); recent intercourse (i.e., previous three months); and use of condoms during recent intercourse. Responses to these questions were reported separately and combined into an ordinal, fourcategory Sex Behavior Index, scored as follows:

(1) no lifetime experience with intercourse; (2) past but no recent intercourse; (3) recent, always protected intercourse; and (4) recent, unprotected intercourse.

Findings

The evaluation showed that the *RFH-CYS* program had a positive effect on the sexual behavior of middle school students at risk for HIV, STDs, and unintended pregnancy. At the initial six-month follow-up, students participating in the *RFH-CYS* program were less likely to report recent inter-

course (21 percent) than students in the *RFH* curriculum-only group (29 percent).¹

Findings from the two-year follow-up evaluation found that *RFH-CYS* participants were significantly less likely than the control group to report sexual initiation through the tenth grade. Those who received the full two years (seventh and eighth grade) of the program (*Community Youth Service* component and the *Reach for Health* curriculum) demonstrated the greatest benefit through the tenth grade. Among those who were virgins in seventh grade, 80 percent of males in the curriculum-only class had initiated sex, compared with 62 percent of those who received one year of *CYS*, and 50 percent of those who received two years of *CYS*. Among females, the figures were 65 percent, 48 percent, and 40 percent, respectively.

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¹ A quasi-experimental evaluation found that RFH-CYS students scored lower on the sexual behavior index than those in the control group, with the greatest effect among those who received the most intensive program (RFH-CYS). This quasi-experimental evaluation also found that RFH-CYS participants were less likely to report recent sexual activity than the control group.

Program Profile Grid

Middle School Programs

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	Profile	Experimenta Design	Positive Progam Impacts	Curriculum Available
1. Abstinence and Sex Education Programs				
Draw the Line/Respect the Line	•	•	Sexual initiation Sexual activity	•
McMaster Teen Program	•	•	Sexual initiation Pregnancy Contraceptive use	•
Postponing Sexual Involvement (PSI), Human Sexuality, and Health Screening	•	•	Sexual initiation Contraceptive use	•
Making a Difference! An Abstinence-Based Approach to HIV/STDs and Teen Pregnancy Prevention	•	•	Sexual initiation Condom use	•
Postponing Sexual Involvement PSI/ENABL	•	•	No positive impacts	S =
Project SNAPP (Skills and kNowledge for AIDS and Pregnancy Prevention)	•	•	No positive impacts	S =
Healthy for Life			No positive impacts	5
2. HIV/AIDs and Other STD Education Programs				
Focus on Kids			Condom Use	
Making Proud Choices! A Safer-Sex Approach to HIV/STDs and Teen Pregnancy Prevention	•	•	Condom Use Sexual activity	•
Youth AIDS Prevention Project (YAPP)	•	•	Condom Use Sexual activity	•
AIDS Risk Reduction Education and Skills Training (ARREST)	•	•	No positive impacts	S =
3. Service Learning Programs				
Reach for Health Community Youth Service Learning (RFH-CYS)	•	•	Sexual initiation Sexual activity	•



The mission of the National Campaign to Prevent Teen Pregnancy is to improve the well-being of children, youth, and families by reducing teen pregnancy. The Campaign's goal is to reduce the teen pregnancy rate by one-third between 1996 and 2005. The National Campaign is a nonprofit, nonpartisan organization supported largely by private donations.

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